CARDIOLOGY CENTER

Kusay Barakat, M.D., F.A.C.C **Shawn Buki, M.D., F.A.C.C.**
Michael Levangie, M.D., F.A.C.C. **Chen Tung, M.D., F.A.C.C.**
David Yu, M.D., F.A.C.C. **Sana S. Shah, M.D., F.A.C.C.**

Dear Patient:

Thank you for choosing the Cardiology Center to assist in your medical care. We look forward to seeing you for your office visit/consultation scheduled on_____at_____am/pm.

Please read the enclosed information regarding our practice. You will find:

- A patient information pamphlet about the Cardiology Center for you to keep.
- A copy of the Cardiology Center's financial policy for your records.
- Cardiology Center's Notice of Privacy Practices for you to keep.
- An acknowledgement form indicating that we provided you with a copy of our Notice of Privacy Practices. **Please complete and sign the acknowledgement. At the bottom of the form, indicate anyone to whom we may communicate your medical information, such as test results or appointment reminders. Please be sure to bring this form to your appointment.**
- A patient registration form. **Please complete the form, sign and date at the bottom, and bring with you to your appointment.**
- A two-sided medical history form. **Please complete both sides and bring with you to your appointment.**

There is a $100.00 fee for NO SHOWS. If you cannot keep your appointment, please call us at 301-694-5900.

Please bring your insurance card(s), a valid referral if one is required by your insurance plan, and your co-payment. For your convenience, we accept cash, personal checks, VISA and,MasterCard.

In an effort to best coordinate your care, please bring a list of your current medications including strengths and dosages, or if it is easier, simply bring all of your prescription bottles with you at the time of your visit.

Sincerely,

Drs. Barakat, Buki, Levangie, Tung, Yu and Shah

Cardiology Center

310 West 9th Street
Frederick, MD 21701
(301) 694-5900

PLEASE PRINT CLEARLY

	Patient's Name (First)	(MI)	(Last)	(Suffix)	Gender M F	Birthdate & Age		
Marital Status	Spouse's Name (First)	(MI)	(Last)	(Suffix)	Patient's Cell Phone ( )			
Patient's Home Address	Apt #	City	State	Zip Code	Patient's Home Phone ( )			
Patient's Employer	Address			Patient's Occupation	Patient's Work Phone ( )			
Spouse's Employer	Address			Spouse's Occupation	Spouse's Work Phone ( )			
Financially Responsible Person O Self O Spouse O Parent O Other	Resp Person's Name (if different from patient)			Resp's Home Phone ( )	Resp's Work Phone ( )			
Address of Responsible Person (if different from patient)				Patient's Primary Care Dr	Referred by			
Patient's email address								
Person to notify in emergency (other than spouse)	Relationship to patient	Home Phone ( )		Work Phone ( )	Cell Phone ( )			

INSURANCE INFORMATION

Primary Insurance Co. Name	Policy Holder's Name / Date of Birth			Policy Holder's Relationship to Patient O Self O Spouse O Parent O Other				
Primary Insurance Co. Address				Policy/ID #	Group #			
Secondary Insurance Co. Name	Policy Holder's Name / Date of Birth			Policy Holder's Relationship to Patient O Self O Spouse O Parent O Other				
Secondary Insurance Co. Address				Policy/ID #	Group #			

PATIENT'S AUTHORIZATION

I hereby authorize Cardiology Center to apply for benefits on my behalf for covered services rendered by Cardiology Center. I request payment from my insurance carriers be made directly to Cardiology Center (or in case of Medicare Part B benefits, to myself or to the party who accepts assignment). I understand that I am financially responsible for any fees and charges deemed as my responsibility according to Cardiology Center and my health plan.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration and/or Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original. Either my insurance carrier or I may revoke this authorization in writing at any time.

_____ _____

Date Signature of Patient, Policy Holder, Beneficiary or Responsible Party

CHART NUMBER: _____

CARDIOLOGY CENTER
HEALTH HISTORY

PLEASE FILL OUT THE INFORMATION BELOW TO THE BEST OF YOUR ABILITY

Patient Name:_____ Date of Birth:_____ Date:_____

Primary Care Physician:_____ Specialist(s):_____

PAST MEDICAL HISTORY
Have you ever had the following: (circle "no" or "yes" or leave blank if uncertain)

Rheumatic Fever	no	yes	Sleep Disorder	no	yes	Cancer	no	yes
Heart Disease	no	yes	Blood Clot (legs/lungs)	no	yes	Kidney Disease	no	yes
Heart Murmur	no	yes	Blood Disorder	no	yes	Liver Disease	no	yes
High Blood Pressure	no	yes	Anemia	no	yes	Hepatitis	no	yes
Elevated Cholesterol	no	yes	Ulcers	no	yes	Depression	no	yes
Pneumonia	no	yes	Reflux/ Heartburn	no	yes	Arthritis	no	yes
Tuberculosis	no	yes	Bleeding Tendency	no	yes	Glaucoma	no	yes
Emphysema	no	yes	Diabetes	no	yes	Other (please list)		
Chronic Bronchitis	no	yes	Thyroid Disorder	no	yes	_____		
COPD	no	yes	Adrenal Disorder	no	yes	_____		
Asthma	no	yes	Neurologic Disorder	no	yes	_____		
Sinus Infections	no	yes	Stroke/TIA	no	yes	Current Weight _____ lbs.		
Hay Fever	no	yes	Seizure Disorder	no	yes	Height _____ ft. _____ in.		

PERSONAL HABITS:

Tobacco Use	no	yes (_____ pack(s) per day)
Alcohol Use	no	yes (_____ drink(s) per day)
Drug Use	no	yes
Caffeinated Drinks	no	yes (_____ drink(s) per day)

FAMILY HISTORY OF HEART DISEASE:

Heart Attack	no	yes
Sudden Death	no	yes
Abnormal Heart Rhythm	no	yes
Heart Failure	no	yes

CURRENT MEDICATIONS AND DOSAGES:

_____
_____
_____
_____

MEDICATION ALLERGIES (include reaction):

_____
_____
_____
_____

CHART NUMBER: _____

PREVIOUS SURGERIES:

_____
_____
_____
_____

PREVIOUS HOSPITALIZATIONS:

_____
_____
_____
_____

REVIEW OF SYSTEMS:
Do you have now or have you had within the past year:
(circle "no" or "yes" or leave blank if uncertain)

Weakness or paralysis	no	yes	Persistent hoarseness	no	yes	Constipation	no	yes
Tire easily or weakness	no	yes	Sore throat	no	yes	Rectal bleeding	no	yes
Recent weight changes	no	yes	Sore tongue or gums	no	yes	Black tarry stools	no	yes
Change in appetite	no	yes	Chronic cough	no	yes	Frequent urination	no	yes
Sensitivity to heat or cold	no	yes	Frequent cough	no	yes	Painful urination	no	yes
Persistent fever	no	yes	Sputum production	no	yes	Urinary incontinence	no	yes
Night sweats	no	yes	Shortness of breath	no	yes	Blood in urine	no	yes
Skin trouble or changes	no	yes	Bloody sputum	no	yes	Hemorrhoids	no	yes
Change in hair or nails	no	yes	Wheezing	no	yes	Joint pain or stiffness	no	yes
Headaches	no	yes	Chest pain or discomfort	no	yes	Insomnia	no	yes
Easy bleeding or bruising	no	yes	Ankle swelling	no	yes	Snoring	no	yes
Difficulty with vision	no	yes	Chest palpitations	no	yes	Excessive drowsiness	no	yes
Eye pain	no	yes	Leg cramps with walking	no	yes	Memory loss	no	yes
Ringing in the ears	no	yes	Restless legs	no	yes	Depression	no	yes
Ear pain	no	yes	Difficulty swallowing	no	yes	Dizziness/fainting	no	yes
Frequent nose bleeds	no	yes	Heartburn	no	yes	Breast lumps or discharge	no	yes
Frequent colds	no	yes	Nausea or vomiting	no	yes	Sexual dysfunction	no	yes
Sinus trouble	no	yes	Abdominal pain	no	yes	Menopause	no	yes
Loss of smell	no	yes	Diarrhea	no	yes	Pregnancy or Childbirth	no	yes

Patient's Signature: _____

Physician Notes/Comments:

_____
_____
_____
_____
_____
_____

Physician's Signature: _____

CARDIOLOGY CENTER

Kusay Barakat, M.D., F.A.C.C., M.R.C.P., F.A.C.P

Michael Levangie, M.D., F.A.C.C. **Shawn Buki, M.D., F.A.C.C.**
Chen Tung, M.D., F.A.C.C. **Sana S. Shah, M.D., F.A.C.C.**

David Yu, M.D., F.A.C.C.

ACKNOWLEDGMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the Cardiology Center's Notice of Privacy Practices.

_____ _____
Patient's Signature **Date**

PLEASE CHECK BELOW TO AUTHORIZE OR NOT AUTHORIZE THE CARDIOLOGY CENTER TO LEAVE MESSAGES REGARDING APPOINTMENTS, TEST RESULTS, BILLING, ETC. AT THE VARIOUS LOCATIONS

	AUTHORIZE	DO NOT AUTHORIZE
Home answering machine	_____	_____
With family members at home	_____	_____
Work voice mail	_____	_____
Cell voice mail	_____	_____

Please indicate below, the names and relationships of those who we may speak to regarding your results, appointments, account, etc.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Welcome to the
Cardiology Center and the offices of:

Kusay Barakat, M.D., F.A.C.C.
Shawn A. Buki, M.D., F.A.C.C.
Michael W. Levangie, M.D., F.A.C.C.
Chen Y. Tung, M.D., F.A.C.C.
David R. Yu, M.D., F.A.C.C.
Sana S. Shah, M.D., F.A.C.C.

Our goal is to provide you with the best cardiovascular care possible. We value your confidence in selecting us to participate in your medical care. This brochure has been designed to anticipate some of your questions and to explain to you our office procedures.

Directions to our office:

From Route 15: Take the 7th Street exit. At the end of the exit ramp, turn left onto West 7th Street. Go approximately ½ mile and at the light in front of Frederick Memorial Hospital, turn left onto Toll House Avenue. Go two blocks to the end of Toll House Avenue and turn right onto West 9th Street. Make the first right into the parking lot of the Ninth Street Medical Center. We are in building A which is on the right. Our office is comprised of six suites. Enter the office through the appropriate door as follows:

Dr. Barakat or Dr. Shah -- Door #1
Dr. Levangie or Dr. Tung -- Door #2
Diagnostic Testing -- Door #3
Dr. Buki or Dr. Yu – Door #4

Available Services:

The Cardiology Center provides a variety of onsite testing, including nuclear cardiac imaging, echocardiography, exercise treadmill testing, Holter monitoring, cardiac event monitoring, Vascular Studies, pacemaker / defibrillator evaluation and reprogramming.

Insurance Participation:

Our physicians participate in numerous insurance programs, including but not limited to Carefirst Blue Cross & Blue Shield, Medicare, Maryland Medical Assistance, MDIPA, Optimum Choice, OneNet PPO, Aetna, Cigna, United Healthcare, Coventry, Johns Hopkins Healthcare, Tricare, PHCS, Humana Choice Care, Great West, Informed, NCPPO, Preferred Health Network. For additional information regarding filing of insurance claims, please refer to our more detailed financial policy. If you have questions regarding our participation in your insurance program, our billing office staff will be happy to assist you. The billing office phone is 301-695-3119 or you may reach them by calling the main office number and choosing option #6.

Prescription Refills:

If you require refills on medications prescribed by your Cardiology Center physician, please call your pharmacy directly to request the refills. The pharmacy will then contact us for refill authorization. Please allow 24 hours to process refill authorizations. We regret that we are unable to provide refill authorization on medications prescribed by physicians outside of the Cardiology Center.

Financial Policy:

To help us keep our fees as low as possible, we ask that your copays and/or fees for office visits and tests be paid at the time of service. For your convenience we accept cash, personal checks, VISA and MasterCard. A more detailed financial policy is made available to you describing our policies concerning Medicare, commercial insurance and various managed care plans. Any outstanding bills are due within 30 days of receipt of your statement. We urge you to discuss with our specially trained billing staff any financial difficulties that may arise.

Managed Care Referral Policy:

It is unfortunate that HMOs and other managed care companies have implemented policies that inconvenience both the patient and the physicians. We belong to numerous such plans and abide by our contracts with them. Various insurers have denied us payment because their rules were not followed to the letter, either by us or by our patients. Therefore, we ask that you help us adhere strictly to the procedures of your plan. If an authorized referral is needed for any treatment, it is your responsibility to have all necessary forms at the time of the visit. Several physician offices refuse referrals over the phone and time we spend on hold increases the waiting time for all of our patients. As a result, it is our policy that if a referral is not available at the time of service and you wish to be seen, we will ask for a signed waiver and a check or credit card imprint. If the referral is received by 4:00pm the following business day, your payment will be returned or credited. If this is not acceptable, you may choose to reschedule your appointment when your referral is available.

Appointments:

Patients are seen by appointment only. Appointments can be scheduled by calling during regular office hours. If you find it necessary to change an appointment, please contact the office at least 24 hours in advance. This courtesy enables us to schedule other patients needing treatment. Occasionally, we will run behind schedule due to unforeseen emergencies. If this happens, we ask your understanding and patience. Our physicians' regular office hours are Monday through Friday, 8:30am to 5:00pm. Some testing appointments are available as early as 7:00am. The Cardiology Center has a physician on call at FMH at all times. As a result, when your physician is scheduled to cover the hospital emergencies, we may occasionally need to reschedule your appointment. If this occurs, you will receive a call or letter from us requesting that you reschedule your appointment. We regret any inconvenience this may cause and sincerely appreciate your cooperation.

Emergencies:

If you have a cardiac emergency, please go directly to the Emergency Department of the **nearest** hospital. During regular office hours, if you have an urgent problem, please call the office telephone number 301-694-5900. Our office staff will contact the doctor with your message and instruct you on what to do. After regular office hours, to reach the cardiologist who is on call for our practice, please contact Frederick Memorial Hospital at 240-566-3300 and select " 0 " (zero) for the hospital operator.

Telephone Calls:

We are always happy to help you with any concerns you may have regarding your care. Calls regarding appointments, billing, insurance matters and all non-emergency medical questions should be made during regular office hours. For questions regarding your medical care, please provide a brief description of your problem. Our staff member will speak with the physician and relay instructions to you.

CARDIOLOGY CENTER

310 West Ninth Street
Frederick, MD 21701

PATIENT INFORMATION
BROCHURE

301-694-5900
Fax: 301-698-9236
Billing: 301-695-3119

CARDIOLOGY CENTER

310 West Ninth Street
Frederick, MD 21701
(301) 694-5900

FINANCIAL POLICY

Insurance Holders

We are happy to file an insurance claim for you, but we will require a copy of your insurance card(s), payment of any copays, deductibles or non-covered services at the time of your visit. Payment in full is due 30 days from the date of service.

Medicare Patients

We are participating physicians in the Medicare program. We will file all charges for services rendered with your Medicare Intermediary. We do not require payment of your deductible or 20% liability at the time of service. We will balance bill you after Medicare (and your secondary carrier if you have one) has processed your claim, however, we will expect payment from you within 30 days of your statement receipt.

Blue Shield Plan Holders

All of our physicians are participating with Carefirst Blue Cross/Blue Shield (both Maryland and DC) as specialists. You are responsible for any copays, deductibles and any other patient liabilities as determined by your plan. If you have a managed care plan that requires referrals, it is your responsibility to obtain the proper paper referral.

Managed Care Plan Holders

We are specialist providers in many managed care plans. All services provided under these plans are subject to appropriate referral requirements from your primary care physician. You will be responsible for all plan requirements, including obtaining referrals prior to your appointment and paying any copays at the time of service. Most managed care plans do not require a copay if you are scheduled only for testing without having a visit with your doctor. Therefore we routinely do not collect copays for straight diagnostic testing. If your insurance company pays your claim, and it is determined that you do owe a copay, a bill will be sent to you. Payment is expected from you within 30 days of your statement receipt.

Filing Claims for Private Insurance

If any insurance claim is filed for you, we will wait 45 days for reimbursement. If we do not receive payment, you will be billed and prompt payment is expected. Any disputes regarding coverage should be handled between you and your insurance company. We will do our best to provide the insurance company with the appropriate information to process your claim, but the ultimate financial responsibility is yours.

Self-Paying Patients

For patients without health insurance coverage there will be a $150 fee for the first visit payable prior to the appointment. If a follow up visit is necessary further financial arrangements can be made with our billing department at 301-695-3119.

Appointment Cancellations

Our practice makes every attempt to provide quality care to our patients and to provide needed testing in a timely fashion. Some of our tests are 4-hour appointments. We ask the courtesy of 24-hour notification if you are unable to keep any appointment. In the event that you do not notify us that you cannot make your scheduled testing appointment, you will be charged a $100.00 rescheduling fee. This fee is not covered by your insurance and prompt payment is expected from you in compliance with our office policy.

We hope the above will help clarify your financial participation and enable us to better serve your medical needs. We urge you to discuss with our specially trained billing staff any special insurance needs or financial difficulties that may arise for you.

OTHER USES OF YOUR HEALTH INFORMATION MADE *WITH* YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your health information will be made only with your written authorization, unless otherwise permitted or required by law. You may submit a completed Authorization for Disclosure Form. You may revoke this authorization at any time, in writing, except to the extent that the practice has taken action in reliance on the use or disclosure indicated in the authorization. You have the opportunity to agree or object to the use or disclosure of all or part of your health information. If this is not possible, your physician will use professional judgment to determine whether the disclosure is in your best interest. In this case, only the health information that is relevant to your health care will be disclosed.

OTHER USES OF YOUR HEALTH INFORMATION MADE *WITHOUT* YOUR WRITTEN AUTHORIZATION

We may use or disclose your health information in the following situations without your consent or authorization, subject to all applicable legal requirements and limitations:

When required by law, public health risks, communicable diseases, health oversight activities, abuse or neglect, Food and Drug Administration, legal proceedings, law enforcement, criminal activity, workers' compensation, organ or tissue donation, research, national security, medical examiners and family or friends (only if we obtain your verbal agreement or if we give you an opportunity to object to such a disclosure and you do not raise an objection or you are not capable of giving your verbal consent).

Please be assured that everyone at the Cardiology Center has always placed your confidentiality and privacy as a top priority. We value your trust and confidence in our staff.

Our Notice of Privacy Practices will be prominently posted in this office where registration occurs. Patients will be provided a hard copy.

We are required to notify you by mail or email of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.

If you believe your privacy rights have been violated, you may file a written complaint with our Privacy Officer, Dr. Kusay Barakat, at the address below or by calling the Secretary of the Dept. of Health and Human Services Office of Civil Rights at 866-OCR-PRIV. You will not be penalized for filing a complaint. You must file your complaint within 180 days of knowing or perceived knowing that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS for good cause shown.

Cardiology Center
310 West Ninth Street
Frederick, MD 21701
Phone 301-694-5900 Fax 301-698-9236

CARDIOLOGY CENTER

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003
Last Revision: Sept 1, 2013

OUR RESPONSIBILITIES:

We are required by law to maintain the privacy of your health information. In addition, we are to provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you and seek your acknowledgement of receipt of this notice. We must abide by the terms of this Notice of Privacy Practices, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means or at alternate locations. We reserve the right to change the terms of our notice at any time. At your request, we will provide you with a revised Notice of Privacy Practices at your next appointment. We will not use or disclose your health information without your written authorization, except as described in this notice.

YOUR RIGHTS:

Unless otherwise required by law, your health record is the physical property of our office. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the Notice of Privacy Practices relating to your health information, to request communications of your health information by alternative means or at alternate locations and to revoke your authorization to use or disclose your health information except to the extent that action has already been taken. We are not required to agree to the requested restriction(s).

You have the right to request a copy of your health information by submitting a Request to Inspect & Copy PHI Form. If your request is denied, you may ask that the denial be reviewed. The person reviewing the denial will not be the same person who denied your request.

You have the right to ask us to amend your health information if you believe it is incorrect or incomplete. You must complete and submit a Request for Correction or Amendment of PHI Form.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

A) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

B) Is not part of the health information that we keep.

C) You would not be permitted to inspect or copy.

D) Is accurate and complete.

You have the right to request a restriction of the health information we may disclose. You may complete and submit the Request for Limitations and Restrictions of PHI Form. If we do agree, we will comply unless the information is needed to provide you emergency treatment.

ACCOUNTING OF DISCLOSURES:

You have the right to request an "accounting of disclosures." To obtain this list, you must submit your request in writing. It must state a time period which may not include dates before April 14, 2003. We may charge you for the cost of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

CHANGES TO THIS NOTICE:

We reserve the right to change or revise this notice at any time and at our discretion, which will be effective for information we already have about you as well as any information we receive in the future. You are entitled to a copy of the notice currently in effect.

EXAMPLES OF DISCLOSURES FOR:

1. ***Treatment:*** Information obtained by your physician will be recorded in your record and used to determine the course of treatment that should work best for you. We may use your health information to contact you as a reminder that you have an appointment for treatment or testing at our office. Your health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Different personnel in our office may share information about you to people who do not work in our office in order to coordinate care, such as phoning in prescriptions to your pharmacy and communicating with other health care providers to coordinate care.

2. ***Payment:*** A bill may be sent to you or your insurance company. The information on the bill may include information that identifies you as well as your diagnosis and procedures. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, etc.

3. ***Healthcare Operations:*** Members of our staff may use information in your health record in an effort to continually improve the quality and effectiveness of the care and service we provide. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer and how we can become more efficient. Other activities include, but are not limited to, internal quality control and assurances including auditing of records.