



Dear

Welcome to Cardiac Study Center!

In order to serve you better, we are enclosing the following:

- | | |
|--|---|
| <input type="checkbox"/> Cardiac Risk Factors | <input type="checkbox"/> Do I Need a PAD test |
| <input type="checkbox"/> New Patient Medical History | <input type="checkbox"/> Red Flag Rules |
| <input type="checkbox"/> Patient Registration | <input type="checkbox"/> Physician Biography |
| <input type="checkbox"/> Directions to Our Offices | <input type="checkbox"/> Walking Impairment Questionnaire |
| <input type="checkbox"/> Payment Policy | <input type="checkbox"/> No Show Policy |
| <input type="checkbox"/> Authorization to Release HealthCare Info Orally | <input type="checkbox"/> Notice of Privacy Practice |
| <input type="checkbox"/> All of the Above | |

At Cardiac Study Center it is our goal to make sure your visits with us go smoothly. Prior to your first visit, please take a few minutes to complete the enclosed forms and bring them with you to your appointment. Please plan on arriving **30 minutes** early to check in, this will allow time to verify that we have all of your paperwork completed. **We would appreciate it if you could call Business Office at (253) 572-7320, M-F 9am – 4pm to pre-register a couple of days before your appointment.**

Please bring with you:

- **Photo ID**
- **All of the medications you are taking**, including over the counter medications, herbal supplements, vitamins etc. This will enable us to obtain the correct spelling, dosage and the prescribing physician. Our staff will complete a medication list during your first visit. This list will be updated at each subsequent visit.
- **Insurance card(s)**. Some insurance companies require we have a valid referral prior to your visit. If your insurance requires a referral, please verify with your primary care physician before your visit that a referral has been completed.

We look forward to seeing you at your appointment scheduled with Dr. _____

on _____ at _____ in our _____ office.

We look forward to seeing you at your appointment scheduled with Dr. _____

on _____ at _____ in our _____ office.

Sincerely,

The staff at Cardiac Study Center



Tacoma (253) 572-7320
 Puyallup (253) 841-4347
 Lakewood (253) 588-7778
 Gig Harbor (253) 851-0404

Patient Registration CSC Account # _____

Last Name		First		Middle Initial	
Address			City		State Zip Code
Primary Phone ()		Secondary Phone ()		Spouse's Name	
Patient's Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth / /	Patient Social Security #		Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/> Widower <input type="checkbox"/> Divorced <input type="checkbox"/>	
Patient's Employer		Employer Phone #		Occupation	
Referred to Cardiac Study Center by Last First			Phone Number		
Family Doctor Last First			Phone Number		

Insurance Information

Primary Insurance Company		Patient Is Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>			
Subscriber ID #		Group #			
Insurance Address					
Subscriber Name and Address if Different From Patient					
Subscriber's Social Security #		Subscriber's Employer		Subscriber's Date of Birth	

Secondary Insurance Company		Patient Is Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>			
Subscriber ID #		Group #			
Insurance Address					
Subscriber Name and Address if Different From Patient					
Subscriber's Social Security #		Subscriber's Employer		Subscriber's Date of Birth	

In Case of Emergency, Please Notify: (Friend or Relative not living with you)

Name	Phone	Relationship
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I request that payment of authorized medicare benefits and/or other insurance benefits be made either to me or on my behalf to the physician for any services furnished to me by that physician. I shall be personally responsible for any unpaid balance to the doctor. I authorize any holder of medical information about me concerning my examination, and/or treatment to release or submit electronically to the centers for Medicare and Medicaid services, its agents and/or my insurance carrier(s) any information needed to determine these benefits of the benefits payable for related services.

Patient Signature

Date



**No Show/Cancellation/Reschedule Financial Penalty Policy
Acknowledgement Form**

In an effort to provide better access for our patients to be seen in a timely manner we have now found it necessary to implement a No Show/Cancellation/Reschedule Policy.

It is CSC's general policy that for:

Consultations, Treadmills, Office Visits and Cardiac Monitors (KOH, Holter, Heart Card):

If a patient no-shows or does not cancel or reschedule an appointment 24 hours prior to the scheduled appointment time we will implement a \$40.00 charge directly to the patient. CSC will not bill insurance companies for this fee.

Echo, Vascular Testing:

If a patient no-shows or does not cancel or reschedule an appointment 48 hours prior to the scheduled appointment time we will implement a \$100.00 charge directly to the patient. CSC will not bill insurance companies for this fee.

Nuclear, CT Testing:

If a patient no-shows or does not cancel or reschedule an appointment 48 hours prior to the scheduled appointment time we will implement a \$200.00 charge directly to the patient. CSC will not bill insurance companies for this fee.

This is to acknowledge that I have read and understand the No Show/Cancellation/Reschedule Policy for Cardiac Study Center, INC., P.S. and understand that not following the guidelines set above will result in a financial charge being billed to me directly.

Signature: _____

Account Number: _____

Date: _____

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.

Cardiac Study Center respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you authorize us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires use to get your authorization to disclose this information for payment purposes. You may have signed an authorization with your insurance company allowing us to disclose information to them or we may request you sign an authorization with us.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For Treatment

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For Payment

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include diagnoses, procedures performed, or recommended care. You may have signed an authorization with your insurance company allowing us to disclose information to them or we may request you sign an authorization with us.

For Health Care Operations

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and train our staff.
- We may contact you by phone or by mailing a reminder card, to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
 - Medical quality review by your health plan;
 - Accounting, legal, risk management, and insurance services;
 - Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of Cardiac Study Center. The protected health information in it, however, generally belongs to you.

You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. Any request granted, will be honored.
- Request and receive from us a paper for a copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make a request for a copy of your records in writing. We have a form available for this type of request. You may contact Wendy Anderson to make an appointment to see your medical chart.
- Have us review a denial of access to your health information-except in certain circumstances (example: information deemed to cause danger to the life or safety of any individual; if disclosing the information would identify an individual who provided information in confidence, etc.)
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of where we have disclosed (given copies) of your health information. The list will not include disclosures to third-party payors (insurance companies). You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in a 12-month period.
- Ask that your health information be given to you by another means (example: orally or via fax) or at another location (example: mailed to you). Please sign, date and give us your request in writing. We do have forms available for these types of questions.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during the business hours of 8 am - 4 pm, please contact:

Wendy Fitch, Compliance Officer (253) 396-4806

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our check-in desk to pick one up.

To Ask For Help Or Report A Problem

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: **Wendy Fitch, Compliance Officer (253) 396-4806 between 8 am and 4 pm.**

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Wendy Fitch at our practice. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- We may release health information orally about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps with your health care bills. We may tell your family or friends your condition and that you are in the hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- You have the right to object to this oral disclosure of your information. If you object, we will not disclose it. We will request that you give us your objection in writing.

We May Use and Disclose Your Protected Health Information Without Your Authorization as Follows:

- **With Medical Researchers:** if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners:** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant):** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA):** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws:** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:** to prevent or reduce a serious or immediate threat to the health or safety of a person or the public.
 - To public health or legal authorities:
 - to protect public health and safety
 - to prevent or control disease, injury or disability
 - to report vital statistics such as births or deaths
- **To Report Suspected Abuse or Neglect:** to public authorities.
- **To Correctional Institutions:** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes:** such as when we receive a subpoena, court order, or other legal processes, or you are the victim of a crime.
- **For Health and Safety Oversight Activities:** for example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes:** for example, we may share health information with disaster relief agencies to assist in notification of your condition to family members or others.
- **For Work-Related Conditions That Could Affect Employee Health:** for example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of the U.S. and Foreign Military Personnel:** for example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings:** at your request, or as directed by subpoena or court order.
- **For Specialized Government Functions:** for example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.



Tacoma (253) 572-7320
Puyallup (253) 841-4347
Lakewood (253) 588-7778
Gig Harbor (253) 851-0404

Notice of Privacy Practices Acknowledgement

We keep a record of health care services we provide you. You may ask to see and obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Wendy Fitch at (253) 396-4806 between 8 am and 4 pm Monday through Friday.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or Legally Authorized Individual Signature

Date

Printed Patient Name

CSC Account Number

Printed Name if Signed on Behalf of the Patient
(parent, legal guardian, personal representative)

Relationship

_____ Patient declined Notice of Privacy Practices

_____ Patient declined to sign Notice of Privacy Practices Acknowledgement

CSC Employee First and Last Name

Date

This form will be retained in your medical record.



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Gig Harbor (253) 851-0404

Authorization to Release Health Care Information Orally

Patient's Name _____ Date of Birth _____

Previous Name _____

We have a legal obligation to keep your personal health care information confidential. For convenience, some patients wish to allow relatives, or others access to test results or other orally transmitted health care information. If you wish to allow anyone to receive such verbal information, please list his or her name and relationship to you in the spaces provided. Copies of your chart or other written information are not covered by this authorization. This authorization will remain in effect until revoked in writing.

Patient Signature

Date

Name

Relationship

This form will be retained in your medical record.



Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Circle “Yes” or “No”:

- | | | | |
|----|---|-----|----|
| 1. | Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is Relieved by rest? <small>(440.21)</small> | Yes | No |
| 2. | Do you experience any pain at rest in your lower leg(s) or feet? <small>(440.22)</small> | Yes | No |
| 3. | Do you experience foot or toe pain that often disturbs your sleep? <small>(440.22)</small> | Yes | No |
| 4. | Are your toes or feet pale, discolored, or bluish? <small>(444.22)</small> | Yes | No |
| 5. | Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? <small>(440.23)</small> | Yes | No |
| 6. | Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? <small>(443.9)</small> | Yes | No |
| 7. | Have you suffered a severe injury to the leg(s) or feet? <small>(904.8)</small> | Yes | No |
| 8. | Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? <small>(440.24)</small> | Yes | No |

Walking Impairment Questionnaire (WIQ)

Patient Name _____

Date of Birth _____

Walking Impairment: These questions ask about the reasons why you are having difficulty walking. We would like to know how much difficulty you had walking during the past week. By difficulty, we mean how hard it was or how much physical effort it took to walk because of each of these problems.

Peripheral Arterial Disease (PAD) Specific Questions

Degree of Difficulty

		None	Slight	Some	Much	Very
Pain, aching or cramps in your calves or buttocks?	Right Leg	4	3	2	1	0
	Left Leg	4	3	2	1	0
	Both Legs	4	3	2	1	0

Differential Diagnosis

Degree of Difficulty

	None	Slight	Some	Much	Very
1. Pain, stiffness or aching in your joints (ankles, knees or hips)?	4	3	2	1	0
2. Weakness in one or both of your legs?	4	3	2	1	0
3. Pain or discomfort in your chest?	4	3	2	1	0
4. Shortness of breath?	4	3	2	1	0
5. Heart palpitations?	4	3	2	1	0
6. Other problems (please list)	4	3	2	1	0

Walking Distance: Report the degree of physical difficulty that best describes how hard it was for you to walk on level ground without stopping to rest for each of the following distances during the last week.

Distance

Degree of Difficulty

	None	Slight	Some	Much	Very
1. Walking indoors such as around your home?	4	3	2	1	0
2. Walking 50 feet?	4	3	2	1	0
3. Walking 150 feet (1/2 block)?	4	3	2	1	0
4. Walking 300 feet (1 block)?	4	3	2	1	0
5. Walking 600 feet (2 blocks)?	4	3	2	1	0
6. Walking 900 feet (3 blocks)?	4	3	2	1	0
7. Walking 1500 feet (5 blocks)?	4	3	2	1	0

Walking Speed: Report the degree of difficulty that best describes how hard it was for you to walk one city block on level ground at each of these speeds without stopping to rest during the last week.

Speed

Degree of Difficulty

	None	Slight	Some	Much	Very
1. Walking one block slowly?	4	3	2	1	0
2. Walking one block at an average speed?	4	3	2	1	0
3. Walking one block quickly?	4	3	2	1	0
4. Walking or jogging one block?	4	3	2	1	0

Stair Climbing: For each of these questions, report the degree of physical difficulty that best describes how hard it was for you to climb stairs without stopping to rest during the past week.

Stairs

Degree of Difficulty

	None	Slight	Some	Much	Very
1. Climbing one flight of stairs?	4	3	2	1	0
2. Climbing two flights of stairs?	4	3	2	1	0
3. Climbing three flights of stairs?	4	3	2	1	0

PATIENT IDENTIFICATION

Last Name	First Name	MI	Date C
CSC Account # (if known)		Date of Birth	
Primary Care Provider		Who referred you to us?	
Please state the main reason you have come here to see a cardiologist.			
Is this a new or old condition? Please explain.			

HEART RELATED PAST MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE BELOW DISEASES/ILLNESSES?

Diabetes	Yes	No	Stroke (CVA) or mini-stroke (TIA)	Yes	No
High blood pressure	Yes	No	Heart valve disease	Yes	No
High cholesterol	Yes	No	Murmur	Yes	No
Coronary artery disease (ischemic heart disease)	Yes	No	Aneurysm	Yes	No
Heart attack (myocardial infarction)	Yes	No	Pulmonary embolism	Yes	No
Heart failure (cardiomyopathy)	Yes	No	Rheumatic fever	Yes	No
Arrhythmia (heart rhythm problem)	Yes	No	COPD (emphysema)	Yes	No
Congenital heart disease	Yes	No	Cancer	Yes	No

PLEASE LIST ALL YOUR *HEART RELATED* HOSPITALIZATIONS, PROCEDURES, AND OPERATIONS:



New Patient Medical History

Tacoma (253) 572-7320 - Puyallup (253) 841-4347 - Lakewood (253) 588-7778 - Gig Harbor (253) 851-0404

Last Name	First Name	MI	Date
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OTHER PAST MEDICAL HISTORY

PLEASE LIST ALL YOUR OTHER MEDICAL PROBLEMS, SERIOUS ILLNESSES, HOSPITALIZATIONS, AND OPERATIONS:

SOCIAL HISTORY

Marital status	Single	Smoking history	Current
	Married		Prior
	Divorced		Never
	Widowed	Illicit substance use in the last year	Yes No
Number of children	_____	Number of alcoholic drinks daily	_____
Most recent occupation:		Exercise type:	
Living will	Yes No	Exercise duration (min per session):	_____
Power of attorney	Yes No	Exercise frequency (times per week):	_____

FAMILY HISTORY

PLEASE CIRCLE ANY CONDITION(S) THAT HAS AFFECTED YOUR FOLLOWING FAMILY MEMBER:

Father	Mother	Siblings
Heart attack	Heart attack	Heart attack
Bypass surgery, angioplasty, or stents	Bypass surgery, angioplasty, or stents	Bypass surgery, angioplasty, or stents
Diabetes	Diabetes	Diabetes
High blood pressure	High blood pressure	High blood pressure
High cholesterol	High cholesterol	High cholesterol
Sudden cardiac death	Sudden cardiac death	Sudden cardiac death
Hypertrophic cardiomyopathy	Hypertrophic cardiomyopathy	Hypertrophic cardiomyopathy



New Patient Medical History

Tacoma (253) 572-7320 - Puyallup (253) 841-4347 - Lakewood (253) 588-7778 - Gig Harbor (253) 851-0404

Last Name	First Name	MI	Date
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HEART AND CIRCULATION REVIEW OF HEALTH

HAVE YOU HAD ANY OF THE BELOW CONDITIONS RECENTLY?

Chest pain	Yes	No	Shortness of breath waking from sleep	Yes	No
Chest discomfort	Yes	No	Swelling in the legs	Yes	No
Shortness of breath at rest	Yes	No	Passing out (syncope)	Yes	No
Shortness of breath with exertion	Yes	No	Heart racing / pounding (palpitations)	Yes	No
Shortness of breath lying in bed	Yes	No	Pains in the legs with walking	Yes	No
How far can you walk before you have to stop? And why would you have to stop (what limits you)?					

REVIEW OF GENERAL HEALTH

HAVE YOU HAD ANY OF THE BELOW CONDITIONS RECENTLY?

Change in weight	Yes	No	Vomiting	Yes	No
Dizziness	Yes	No	Bleeding from your rectum	Yes	No
Weakness	Yes	No	Blood in your urine	Yes	No
Fevers	Yes	No	Joint aches or pains	Yes	No
Chills	Yes	No	Muscle aches or pains	Yes	No
Fatigue	Yes	No	Seizures	Yes	No
Blurry vision	Yes	No	Strokes (CVA) or mini-strokes (TIA)	Yes	No
Bleeding from your nose	Yes	No	Skin sores or ulcers	Yes	No
Bleeding from your gums	Yes	No	Pain when pressing chest wall	Yes	No
Shortness of breath	Yes	No	Depression	Yes	No
Cough	Yes	No	Thyroid problems	Yes	No
Asthma	Yes	No	Diabetes	Yes	No
COPD (emphysema)	Yes	No	Easy bruising	Yes	No
Nausea	Yes	No	Bleeding or clotting problems	Yes	No



Patient Name (Please Print): _____
Account Number: _____

We are asking you to complete this form only one time. This form is designed to help us meet the new requirements of the insurance policies that we are contracted with. You will only be asked to complete the form once. Please give this form to the medical technician that brings you back to your room. Thank you in advance!

Cardiac Risk Factors:

Have you ever had or currently have: (Check all that apply) Please use space provided to write in comments where applicable.

- Taking Aspirin If yes, what dose are you taking? _____
- Alcohol Use (If yes, comment how much per day)

- Diabetes Mellitus
- Congestive Heart Failure
- Embolism (Blood Clot) if yes where was the clot?
Leg? _____
Lung? _____
- Hyperthyroidism (High Thyroid Level)
- Hypertension (High Blood Pressure)
- Hyperlipidemia (High Cholesterol)
- Physical Activity
How many times a week do you exercise? _____
What type of physical activity do you do? _____
For how many minutes? _____
No exercise? _____
- Recreational Drug Use
- Smoking History (If yes, how many packs per day and date quit) _____
- Tobacco Use (Yes/No) If yes, how often and what type _____

Has your mother, father, sister, or brother had the following (check all that apply):

- Coronary Heart Disease
- Diabetes Mellitus
- Hyperlipidemia (High Cholesterol)
- Hypertension (High Blood Pressure)

***MEDICAL RECORDS DO NOT SCAN**

Payment Policy

Our intent is to communicate our payment policy, regardless of your insurance status.

All Patients

1. New patients need to bring in all health insurance card(s), Medicare cards, and/or current State Assistance coupons for all current coverages.
2. To prevent billing of services to you, your medical information must be accurate for both your primary and supplementary coverage.
3. All patients will be asked to thoroughly review and confirm the information on their Fee Ticket at each visit. You must advise us of any changes in primary care physician, your insurance carrier, or your personal address or phone number. If you receive new insurance cards, we will need to scan the front and back of your cards.

Co-Payments

You are expected to pay your insurance co-payment at the time of your office visit. Please see the staff at the front desk to make this payment.

Payment Options

You can pay with cash, check, money order, VISA or MasterCard debit or credit cards.

Fee Tickets

If your physician hands you your Fee Ticket, please be sure to leave it with the appointment desk personnel; they will review the ticket for any physician instructions. If you need a copy for your records, we will be happy to make one for you.

Referrals

1. Many insurance plans require that you obtain a referral before being seen or treated by a specialist. Your primary care physician can assist you with obtaining referrals.
2. It is **your** responsibility to request the referral from your primary care physician, but we will assist whenever possible.
3. Also, please be aware that **outside tests**, such as lab work, usually need to be done at a specific lab and **usually will need a referral**. Please contact your primary care physician to confirm where your lab work needs to be conducted, if we order lab work for you.

No Insurance

If you do not have insurance coverage, we do expect you to do your part in paying for the services rendered and we are eager to work with you to reach a mutually agreeable solution. Your local State DSHS office may also be an alternative source of financial assistance.

If you **do not** have insurance coverage, our initial expectations are:

1. You will pay at least \$200.00 at the time of service. Payments are accepted by the front desk personnel at the time of your appointment. The balance is due within 30 days.
2. Balances under \$300.00 may be paid with monthly payment arrangements that settle the balance in full within 90 days. Please contact the Business Office Representative to sign a financial agreement prior to or when you arrive for your appointment.
3. Balances over \$300.00 may be paid with monthly payments for a maximum of 12 months. Please contact the Business Office Representative to sign a financial agreement prior to or when you arrive for your appointment.

Payment Policy Continued.

Billing Issues

We endeavor to bill your insurance coverage correctly. However, billing questions regarding charges or payments do arise.

We invite you to call our Business office at (253) 572-7320, M-F 9am-4pm whenever you need billing information or assistance.

To make financial arrangements, please contact our Business Office Representative, Suzanna, at (253) 396-4819 or (253) 572-7320, M-F 9am-4pm. Suzanna is located in our Tacoma office, but serves all Cardiac Study Center locations.

Red Flags Rule

Effective May 01, 2009

Beginning May 01, 2009 the **Red Flags Rule** goes into effect. In November of 2007 the Federal Trades Commission (FTC) issued a set of regulations, known as the **“Red Flags Rule”**, requiring that certain entities develop and implement written identity theft prevention and detection programs to protect consumers from identity theft. Health care providers and clinics that accept a patient’s payment on terms or from credit cards are considered a creditor, and thereby subject to the new rule.

To meet the guidelines of the new rule Cardiac Study Center will be requiring valid photo ID at the time you present for your appointment. This will enable us to confirm your identity and detect possible identity and/or insurance theft.

You may elect one of the following options:

- You may request that we scan your valid photo ID into our system upon your visit. Then when you check in for future visits we will bring up the valid photo ID picture to confirm your identity.

Or

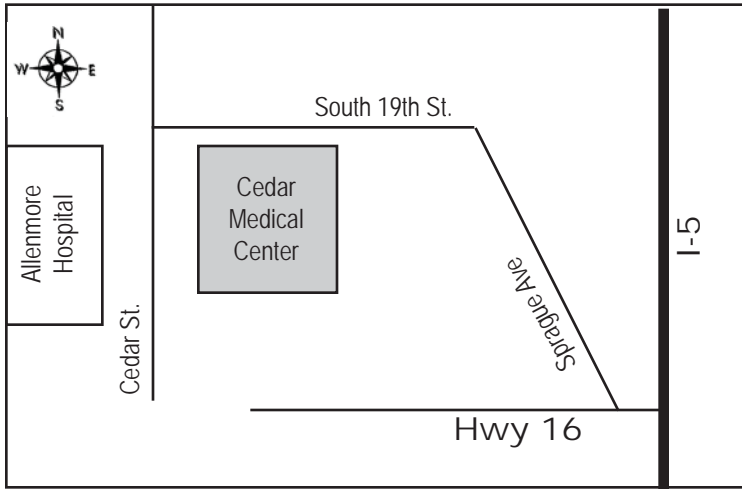
- You may request that we ask for your valid photo ID at check in at each visit.

We appreciate your assistance in our efforts to meet the guidelines of the new **“Red Flags Rule”** and our efforts to ensure our patient’s identity is protected.

If you have any questions regarding the new rule you may contact our Compliance Manager, Wendy Fitch directly at (253) 396-4806 Monday-Friday 7:30am-4:00pm.

May 01, 2009

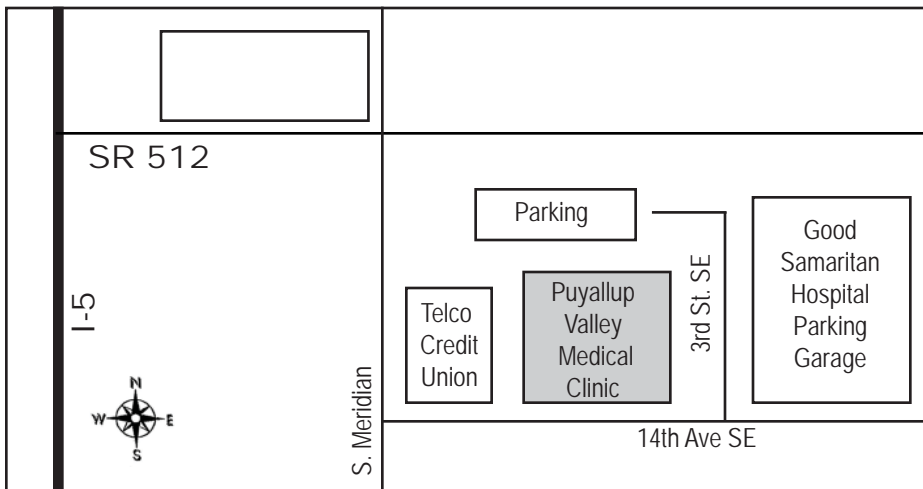
Tacoma 1901 South Cedar Street, Suite 301, (253) 572-7320



- **From I-5**
Take the Gig Harbor/Bremerton Exit (Hwy 16)
Exit at Union St. Turn Right on Union St.
Turn right on 19th St.
*Follow 19th St. East to the second light (Cedar St.)
Cedar Medical Center is on the right side of
19th St. just after the stop light

- **From Gig Harbor**
Take Hwy 16 (east bound)
Take the Union St. exit Turn left on Union St.
Turn right on 19th St. *Follow directions above.

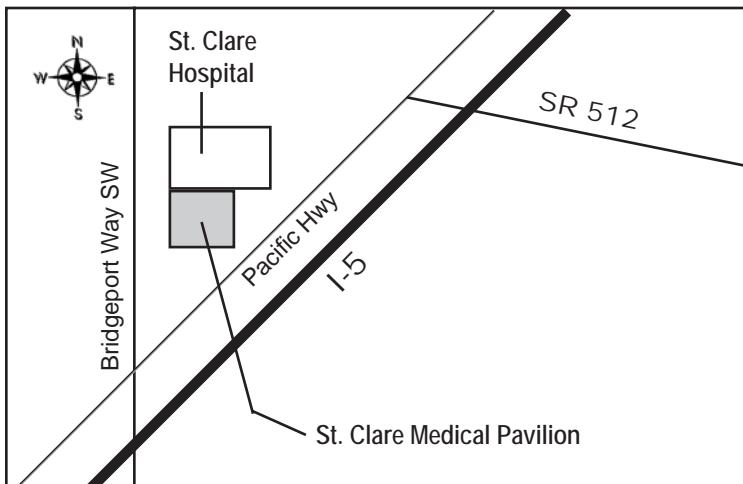
Puyallup 1322 3rd Street, Suite 330, (253) 841-4347



- **From I-5**
Take SR 512 exit (Puyallup east bound)
Take the S. Meridian exit (Puyallup Fairgrounds)
Turn right on S. Meridian and make an immediate
left on 14th
Go up the hill and make a left on 3rd St. (next to Good
Samaritan Hospital parking garage)
Turn left into "Puyallup Valley Medical Clinic" parking lot
Go to "MAIN ENTRANCE," the office occupies the whole
third floor of the clinic.

- **From Hwy 167**
Take Hwy 167 south bound to Hwy 512 east bound
Take the S. Meridian exit (Puyallup Fairgrounds)
Take a left on S. Meridian and make a left onto 14th
Follow the above directions

Lakewood 11311 Bridgeport Way SW, Suite 301, (253) 588-7778

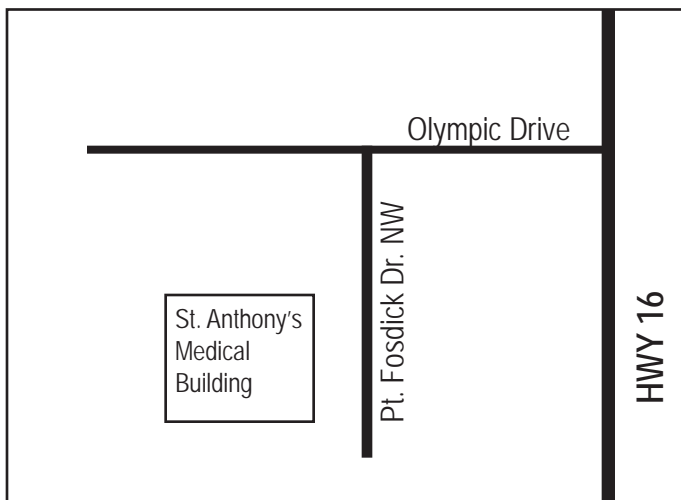


- From I-5, take **Exit 125** Lakewood/McChord AFB.
- **I-5 South**, turn right at the end of the off-ramp at the light onto Bridgeport Way SW.
- **I-5 North**, turn left onto Bridgeport Way SW
- Go about 3/10 of a mile. The office is located on the right in the St. Clare Medical Pavilion.

St. Anthony's Medical Building

4700 Point Fosdick Drive NW, Suite 205

Gig Harbor, WA 98335 (253) 851-0404



From Westbound Highway 16

- Take the Olympic Drive NW exit
- Turn left onto Olympic Drive NW
- Turn left onto Point Fosdick Drive NW
- Turn right into the parking lot of St. Anthony's Medical Building

From Eastbound Highway 16

- Take the Olympic Drive NW exit
- Turn right onto Olympic Drive NW
- Follow above instructions