Precision Heart Rhythm
Jaydutt Patel, Cardiac Electrophysiologist
7640 W Sylvania Ave, Suite G
Sylvania, OH 43560
Phone: 419-754-3278 Fax: 844-812-0035

1. Patient Demographics & Contact Information

Full Legal Name:

Preferred Name: Date of Birth:

Address:

City / State / ZIP:

Mobile Phone: Home Phone:

Email:

Next of Kin / Emergency Contact

Name: **Relationship:**

Phone: **Alt Phone:**

Address (if different):

Individuals Authorized to Receive Medical Information

List people with whom we may share protected health information (PHI) (e.g., spouse, family, caregiver).

Name 1: Relationship: Phone:

Name 2: Relationship: Phone:

Name 3: Relationship: Phone:

I understand I may revoke or modify this authorization in writing at any time.

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Insurance Information

Primary Insurance:

Member ID: Group #:

Policy Holder Name: Holder DOB:

Secondary Insurance (if applicable)

Secondary Insurance:

Member ID: Group #:

Preferred Pharmacy (optional)

Pharmacy Name:

Pharmacy Phone:

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2. Medical History & Electrophysiology Questionnaire

Referring Physician: Reason for visit:

Symptoms / Reason for Visit (check all that apply)

- Atrial Fibrillation / Flutter
- SVT / Palpitations
- Ventricular Arrhythmia
- Bradycardia / Heart Block
- Pacemaker / ICD Management
- Syncope / Near Syncope
- Post-ablation follow-up
- Other (describe below)

Other details:

Cardiac History (check all that apply)

- Prior ablation (date):
- Pacemaker/ICD (implant date):
- Coronary artery disease
- Heart failure / Cardiomyopathy
- Valve disease
- Stroke / TIA

Other cardiac history / procedures:

Current Medications & Allergies

Medications (attach list if needed):

Medication Allergies:

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3. HIPAA Notice of Privacy Practices & Acknowledgment

This practice is required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with notice of our legal duties and privacy practices under HIPAA.

We may use and disclose PHI for treatment, payment, and healthcare operations (TPO), including coordination with referring physicians, hospitals, diagnostic facilities, and your health plan. Disclosures may also be made as required by law (for example, public health reporting).

Your rights include: (1) requesting access to and a copy of your record; (2) requesting amendments; (3) requesting restrictions (we are not required to agree to all requests); (4) requesting confidential communications; (5) receiving an accounting of certain disclosures.

You may file a complaint with the U.S. Department of Health and Human Services or with this practice. You will not be retaliated against for filing a complaint.

Acknowledgment of Receipt

I acknowledge that I have received and reviewed the Notice of Privacy Practices.

Patient/Representative Name:

Signature: Date:

If you are signing as a legal representative, please indicate relationship/authority (e.g., parent, guardian, POA):

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4. Consent for Treatment

I voluntarily consent to medical evaluation, diagnostic testing, and treatment provided by the physicians and staff of Precision Heart Rhythm. I understand that medicine is not an exact science and that no guarantees have been made regarding the outcome of evaluation or treatment. I understand I may ask questions at any time.

Initials: _____

9. Communication Consent (Phone / Text / Email)

I consent to receive appointment reminders, scheduling messages, test/result notifications, and billing communications via:

Phone call / voicemail Text message Email

Preferred contact: _____ Best number/email: _____

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5. Financial Policy & Payment / Fee Notice (Insurance + Self-Pay)

Insurance & Patient Responsibility: Copayments, deductibles, and coinsurance are due at the time of service. Insurance verification is not a guarantee of payment. You are financially responsible for services not covered or denied by your plan.

Self-Pay / Non-Covered Services: Payment is due at the time of service unless prior arrangements are made in writing. Fees for non-covered, elective, or self-pay services will be disclosed in advance when possible.

Credit Card Convenience Fee: A 3% non-refundable convenience fee will be applied to balances paid using a credit card. This fee is not charged on debit card, cash, or check payments. You may choose an alternative payment method to avoid this fee.

Outstanding Balances & Collections: Statements are issued for outstanding balances. Accounts may be sent to collections after 60 days if unpaid. You remain responsible for costs associated with collection of unpaid balances as permitted by law.

Returned Payments: Returned checks or failed electronic payments may be subject to an administrative fee.

Initials (Financial Policy): _____

6. Assignment of Benefits & Insurance Authorization

I authorize payment of medical benefits to this practice for services rendered and authorize release of information necessary to process insurance claims.

Initials (AOB): _____

8. No-Show / Late Cancellation Policy

Appointments not canceled at least 24 hours in advance may incur a fee. Repeated no-shows may result in dismissal from the practice.

Initials (No-Show): _____

7. Telehealth Consent (Optional)

I consent to receive medical services via telehealth when clinically appropriate. I understand the risks and limitations of remote care.

Yes, I consent to telehealth when appropriate No, I decline telehealth services

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10. Master Signature

By signing below, I confirm that the information provided is accurate to the best of my knowledge and that I have reviewed and agree to the terms and acknowledgments contained in this New Patient Intake & Consent Packet, including HIPAA Notice of Privacy Practices acknowledgment, Consent for Treatment, Financial Policy (including the 3% credit card convenience fee), Assignment of Benefits, No-Show policy, and Communication preferences.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

If signing as a Legal Representative (if applicable)

Name: _____ Relationship/Authority: _____

Representative Signature: _____ Date: _____