

**J. Brian Deville, M.D., F.A.C.C.**

**Hafiza H. Khan, M.D., F.A.C.C.**

**Thomas P. Beveridge, M.D.**

Welcome to Arrhythmia Management!

Enclosed you will find several forms necessary for your first visit with our office. Please carefully read over and complete each form at your convenience. Upon completion please bring them to your appointment.

Notice of Privacy Practices

Notice of Privacy Practices Patient Acknowledgement

Medication List

Patient Information Form

Release of Information Authorization

Health History Form

Medicare Patients- there will be a Medicare form for your **signature only**

Regarding insurance: If your insurance company requires you to have a referral from your Primary Care Physician, it is the patient's responsibility to obtain that referral. Referrals can be faxed to our office at 972-964-7865. If your insurance requires a **SPECIALIST OFFICE VISIT COPAY, we accept cash, check, or credit (Master Card & Visa only)**. Please be sure to bring your insurance card and picture identification to our office for each visit along with your co-payment or coinsurance.

Arrhythmia Management is located at:  
**1820 Preston Park Blvd., Suite 1450, Plano, TX. 75093**  
**Near the Southwest corner of Park and Ohio.**

Our physicians specialize in the electrical conduction system of the heart. Because of the nature of our practice, our physicians are frequently called upon to treat emergencies in the hospital as well as in clinic. We cannot predict when our physicians will be called to treat an emergency patient, so please plan your day accordingly. If we have sufficient advance notice, we will call you prior to your appointment to inform you of delays. You may also call us before your appointment to see if our physicians have been delayed. We are happy to reschedule your visit if our physicians are unable to see you at your previously scheduled appointment time.

For your first consultation appointment in our office, please eat, drink and take your customary medications as you would normally do. You should anticipate having an ECG done at each visit, and dress accordingly: A button-down top will allow electrode tabs to be placed easily without requiring you to completely disrobe. Ladies, please do not wear full pantyhose for your first appointment, as access for placing electrode tabs will be too limited.

We look forward to meeting you soon!  
Again, Welcome to Arrhythmia Management!

Patient Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ Middle \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_  
 Phone Number \_\_\_\_\_

Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Social Security No. \_\_\_\_\_  
 Driver's License \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_

Patient's Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Occupation \_\_\_\_\_  
 Phone \_\_\_\_\_  
 E-mail \_\_\_\_\_

Provide the following information if guarantor is different than patient.

Guarantor's Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ Middle \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 SS# \_\_\_\_\_ DOB \_\_\_\_\_  
 Patient's Relationship to Guarantor \_\_\_\_\_

Primary Insurance, Circle One: PPO HMO Other Don't Know  
 Company Name \_\_\_\_\_  
 Claims Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Member Services Phone \_\_\_\_\_  
 Policy No \_\_\_\_\_ Group No \_\_\_\_\_  
 Insured Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
 Insured Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Cardholders Social Security No. \_\_\_\_\_

Secondary Insurance, Circle One: PPO HMO Other Don't Know  
 Company Name \_\_\_\_\_  
 Claims Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Member Services Phone \_\_\_\_\_  
 Policy No \_\_\_\_\_ Group No \_\_\_\_\_  
 Insured Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
 Insured Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Cardholders Social Security No. \_\_\_\_\_

Provide the following information:

Referred by: \_\_\_\_\_ Onset date of current symptoms \_\_\_\_\_  
 Has any member of your family ever been treated at this office? Circle One: Yes No  
 List Current Medications \_\_\_\_\_  
 Are you allergic to any medicine? Yes \_\_\_\_\_ No Don't Know  
 I plan to make payment of my medical expenses as follows: (Circle One or More) Cash Check Visa/MasterCard

**I hereby authorize J. Brian DeVile, MD., PA., to furnish my information to insurance carriers concerning my condition & treatment, and hereby irrevocably assign to the physician all payments for services rendered to my dependents or me. I understand that I am financially responsible for all charges, whether or not covered by insurance. I authorize J. Brian DeVile, MD., PA., to furnish medical records & other documentation to requesting parties for purposes of payment or treatment. I understand that these records may contain information from other healthcare providers, as well as administrative information. I specifically consent to the release of information that may relate to HIV or AIDS infection. I authorize you to transmit this information by facsimile and release you from any liability for breach of confidentiality or misdirection of transmission if my records are transmitted by fax.**

Signature \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## ARRHYTHMIA MANAGEMENT

### AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION ARRHYTHMIA MANAGEMENT (INFORMATION GOING OUT)

I HEREBY AUTHORIZE THE PHYSICIANS AND STAFF OF ARRHYTHMIA MANAGEMENT, WHICH INCLUDES BUT IS NOT LIMITED TO:

- J. BRIAN DEVILLE, M.D., P.A.
- HAFIZA H. KHAN, M.D., P.A.
- THOMAS P. BEVERIDGE, M.D.
- DUSTIN WILLIAMS, N.P.

TO FURNISH INFORMATION AND DOCUMENTATION ABOUT MY DIAGNOSIS, CARE AND TREATMENT TO HEALTHCARE PROVIDERS AND THEIR REPRESENTATIVES, INCLUDING MEDICAL AND EMERGENCY FACILITIES, FOR THE SOLE PURPOSES OF CARE AND TREATMENT. THIS PROTECTED HEALTH INFORMATION MAY ALSO BE FURNISHED FOR THE PURPOSES OF BILLING AND PAYMENT.

MY PROTECTED HEALTH INFORMATION MAY ALSO BE DISCLOSED TO THE FOLLOWING PEOPLE BY ARRHYTHMIA MANAGEMENT STAFF, WRITTEN OR VERBAL TO: (EX: SPOUSE, CHILDREN, AND FRIEND)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

WITH MY CONSENT (PLEASE INITIAL ONE)

\_\_\_\_\_ (initials) ARRHYTHMIA MANAGEMENT MAY CALL MY HOME AND LEAVE A VOICE MAIL ON MY ANSWERING MACHINE, SPEAK TO FAMILY/HOUSEHOLD MEMBERS ANSWERING MY PHONE, SEND MAIL OR EMAIL TO MY HOME IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENT OR OPERATIONS, SUCH AS APPOINTMENT REMINDERS, BILLING INFORMATION, INSURANCE ITEMS AND ANY CALL PERTAINING TO MY CLINICAL CARE, INCLUDING LABORATORY RESULTS.

\_\_\_\_\_ (initials) I DIRECT THAT ARRHYTHMIA MANAGEMENT MAY NOT LEAVE ANY VOICE MAIL MESSAGES ON MY ANSWERING MACHINE OR SPEAK TO ANYONE IN MY HOUSEHOLD OTHER THAN MYSELF.

SPECIAL INSTRUCTIONS \_\_\_\_\_  
\_\_\_\_\_

I UNDERSTAND AND HAVE BEEN PROVIDED WITH A NOTICE OF PATIENT PRIVACY HANDOUT (IN THIS PACKET) THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES. I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AND THAT THE OFFICE IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING, EXCEPT TO THE EXTENT THAT THE OFFICE HAS ALREADY TAKEN ACTION IN RELIANCE THEREON.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

**ARRHYTHMIA MANAGEMENT**

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION  
ARRHYTHMIA MANAGEMENT  
(INFORMATION COMING IN)**

I ALSO AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS IN THEIR ENTIRETY FOR THE PURPOSE OF EXAMINATION, DIAGNOSIS AND TREATMENT FROM ALL PREVIOUS PROVIDERS AND FACILITIES TO:

**ARRHYTHMIA MANAGEMENT  
J. BRIAN DEVILLE, M.D., P.A.  
HAFIZA KHAN, M.D., P.A.  
THOMAS P. BEVERIDGE, M.D.  
1820 PRESTON PARK BLVD., SUITE 1450  
PLANO, TX 75093  
PHONE: (972) 964-0363  
FAX: (972) 964-7865**

I UNDERSTAND THAT THESE RECORDS MAY CONTAIN ADMINISTRATIVE INFORMATION. I SPECIFICALLY CONSENT TO THE RELEASE OF INFORMATION THAT MAY RELATE TO HIV OR AIDS INFECTION. I AUTHORIZE YOU TO TRANSMIT THIS INFORMATION BY FACSIMILE AND RELEASE YOU FROM ANY LIABILITY FOR BREACH OF CONFIDENTIALITY OR MISDIRECTION OF TRANSMISSION IF MY RECORDS ARE TRANSMITTED BY FAX.

PRINTED NAME OF PATIENT:

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PATIENT DATE OF BIRTH:

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PATIENT SOCIAL SECURITY NUMBER:

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SIGNATURE OF PATIENT OR LEGAL GUARDIAN/REPRESENTATIVE:

DATE:

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FOR OFFICE USE ONLY BELOW THIS LINE

FOR IMMEDIATE PHYSICIAN REVIEW, PLEASE FAX RECORDS?

YES  NO

COMMENTS:

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# ARRHYTHMIA MANAGEMENT

## MEDICATION LIST

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ Height \_\_\_\_\_

| MEDICATION: | DOSE: | FREQUENCY: | Date | Date | Date | Date | Date | Date |
|-------------|-------|------------|------|------|------|------|------|------|
|             |       |            |      |      |      |      |      |      |
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|             |       |            |      |      |      |      |      |      |
|             |       |            |      |      |      |      |      |      |

| PROCEDURES/SURGERIES: | DATE: | NOTES: |
|-----------------------|-------|--------|
|                       |       |        |
|                       |       |        |
|                       |       |        |
|                       |       |        |
|                       |       |        |
|                       |       |        |

**PHARMACY:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**FAX:** \_\_\_\_\_

## ARRHYTHMIA MANAGEMENT

### History and Physical Form

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **SSN#:** \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Age:** \_\_\_\_\_

**Telephone Number(s): (Home)** \_\_\_\_\_ **(Work)** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer's Address:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Other Doctors/Specialist you routinely see:** \_\_\_\_\_

|  |   |
|--|---|
| <b>Chief Complaint (Reason for Visit):</b> Check <u>all</u> that apply |   |
| <input type="checkbox"/> Chest Discomfort                              | <input type="checkbox"/> Shortness of breath              |
| <input type="checkbox"/> Dizziness/Lightheaded                         | <input type="checkbox"/> Palpitations or Extra Heartbeats |
| <input type="checkbox"/> Swelling of legs (edema)                      | <input type="checkbox"/> Other Symptoms(explain below):   |
| Other Symptoms: _____  |   |

|   |   |
|---|---|
| <b>Patient's Cardiac Risk Factors:</b> Check <u>all</u> that apply. |   |
| <input type="checkbox"/> High Blood Pressure                        | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> Smoking                                    | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Obesity                                    | <input type="checkbox"/> Previous Stroke  |

#### **Social History:**

**Coffee:** Yes / No If yes, Cups per day: \_\_\_\_\_ Other Caffeine per day: \_\_\_\_\_

**Alcohol:** Yes / No If yes, type of Alcohol: \_\_\_\_\_ Amount per/day or week: \_\_\_\_\_

**Smoking:** Yes / No If yes, Packs/day: \_\_\_\_\_ Years of Smoking: \_\_\_\_\_ Quit when: \_\_\_\_\_

**Exercise/Activity:** Yes / No If yes, type: \_\_\_\_\_ Days per week: \_\_\_\_\_

**Emotional Stress:** Low / Medium / High

| <b>Family History:</b><br>Please check applicable condition(s) and relative(s) to which it applies. | Mother | Father | Sibling | Children | Grandparent(s) |        |
|---|--------|--------|---------|----------|----------------|--------|
|   |        |        |         |          | Mother         | Father |
| Bleeding Disorder   |        |        |         |          |                |        |
| Diabetes  |        |        |         |          |                |        |
| Heart Disease   |        |        |         |          |                |        |
| High Blood Pressure   |        |        |         |          |                |        |
| Heart Rhythm Problems   |        |        |         |          |                |        |
| Stroke  |        |        |         |          |                |        |
| Thyroid Disorder  |        |        |         |          |                |        |
| Kidney Disease  |        |        |         |          |                |        |

**Sleep: Snoring:** Yes / No

**Daytime Drowsiness:** Yes / No

| <b>Other Medical History –Self/Patient (check <u>all</u> that apply)</b> |  |
|--|--|
| <input type="checkbox"/> Headaches                                       | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Gallbladder Disease                             | <input type="checkbox"/> Gout              |
| <input type="checkbox"/> Prostate Disease                                | <input type="checkbox"/> Heart Murmur      |
| <input type="checkbox"/> Urinary Incontinence                            | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Sexual Dysfunction                              | <input type="checkbox"/> Kidney Disease    |
| <input type="checkbox"/> Peripheral vascular disease                     | <input type="checkbox"/> HIV               |
| <input type="checkbox"/> Thyroid Disorder                                | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Frequent Infections                             | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> Thyroid Disorder                                | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Osteoporosis                                    | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Bronchitis/Emphysema                            | <input type="checkbox"/> Pneumonia         |
| <input type="checkbox"/> Peptic Ulcer                                    | <input type="checkbox"/> GI Disorder       |
| <input type="checkbox"/> Panic Attacks                                   | <input type="checkbox"/> Nervousness       |

**Major Accidents:** \_\_\_\_\_

**Childhood significant Illnesses:** \_\_\_\_\_

**Other significant medical problems:** \_\_\_\_\_

# Insurance Informed Consent

Please initial the following that apply

         **ALL INSURANCE PROGRAMS:** We will file your insurance claims for you. If you wish to file your own insurance, we will provide you with a complete statement at the end of each visit. You will be expected to pay in full for services provided if you file your own insurance claims. It is the patient's responsibility to provide our office with the most current form(s) of insurance at each visit. A failure to provide correct insurance information may result in a reduction of your benefits or a denial of payment by your insurance company. You will be responsible for all charges incurred on the pertaining dates of service if a delay in providing insurance information results in a reduction or a denial of payment. Your Specialist co-payment will be due at every visit you see a Doctor. All follow-ups and device checks will be filed to your insurance company and you will be billed for any co-insurance portions your insurance company deems as the patient's responsibility. If your plan requires a deductible, it will be collected prior to any scheduled procedures or operations. We accept cash, check or MasterCard/Visa. If you have any questions regarding the above or your insurance benefits, please ask for assistance at the front desk.

         **SELF PAY OR INSURANCE REIMBURSEMENT FUNDS:** Payment will be required at the end of each appointment. If the amount cannot be paid in full, an appointment will be set with our office manager to set up a manageable payment plan. We will not wait for you, the patient, to be paid by the insurance company before a payment is made towards your account. However, we do not expect you, the patient, to pay for a hospital procedure in full to receive treatment. Please take advantage of our payment plans to help you manage your account.

         I have read, or have had read the above, and understand the terms of Arrhythmia Management's insurance policy.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Insurance Carrier

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## AUTHORIZATION AND ASSIGNMENT

Please initial next to each line that applies to you. Thank You.

       **AUTHORIZATION TO RELEASE INFORMATION:** You are authorized to release any information you, the provider, deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, the provider, or any consequence thereof.

       **ASSIGNMENT OF PAYMENT:** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges, and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible, co-insurance amount or for their co-payment on services provided by J. Brian DeVille, M.D., F.A.C.C., Hafiza H. Khan, M.D., F.A.C.C., Thomas P. Beveridge, M.D., F.R.C.P.C., or the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

       **MEDICARE ASSIGNMENT (if applicable):** I authorized any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

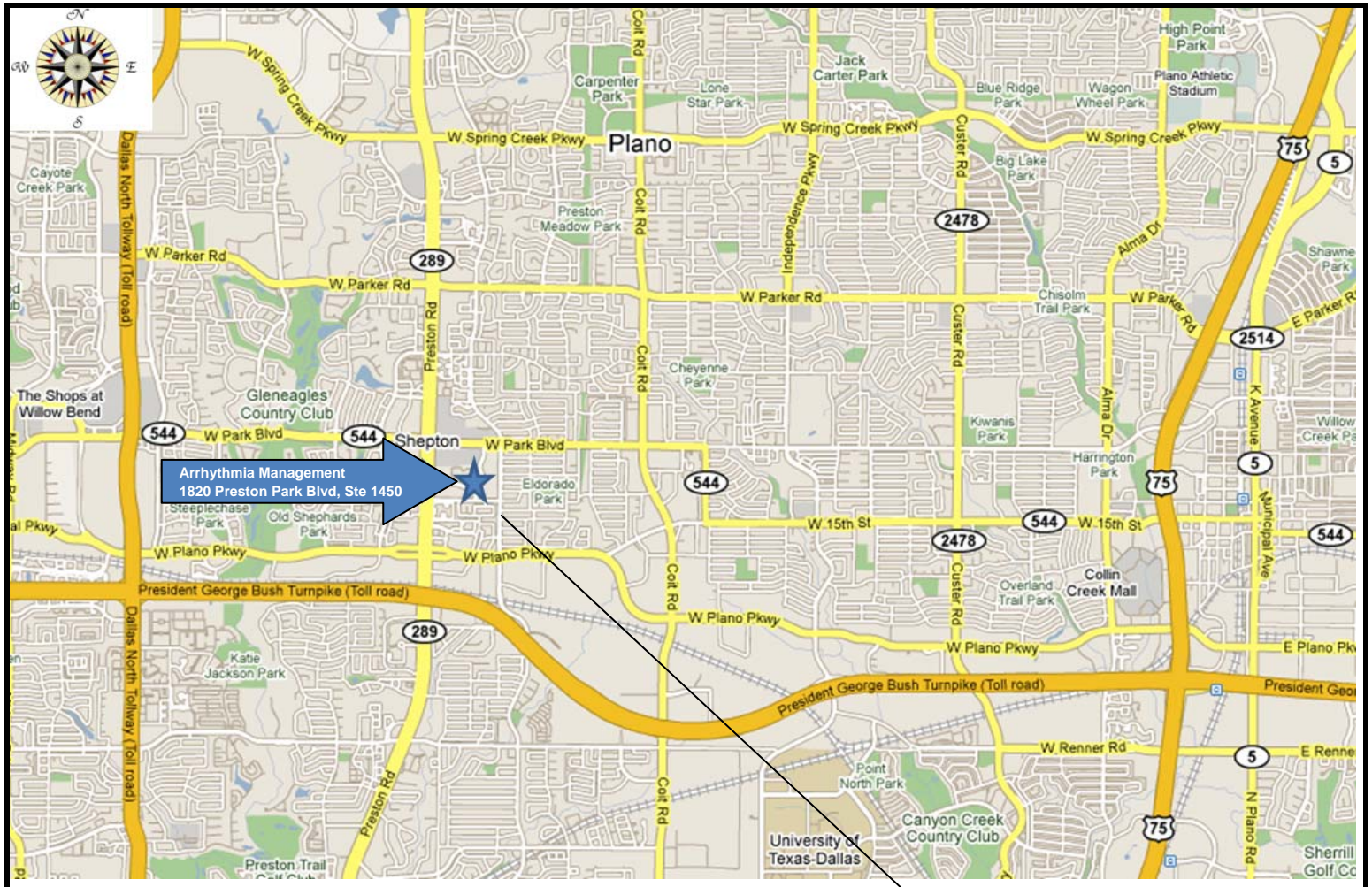
       **I have read or have had read to me, the above consent.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



**Arrhythmia Management**  
1820 Preston Park Blvd, Ste 1450



**Arrhythmia Management**

**H** Heart Hospital Baylor Plano