Cardiology Associates of Michigan, P.C.

50505 Schoenherr, Suite 320, Shelby Township, MI 48315 (586)580-3062
25910 Kelly Rd, Suite B, Roseville, MI 48066 (586)772-3366
4150 River Rd., Suite D East China, MI 48054 (810) 328-4082
46591 Romeo Plank Rd, Suite 131. Macomb, MI 48044 (586) 580-3062

Please print clearly and fill out ENTIRE packet.

PATIENT INFORMATION:

Patient Name: _____
LAST FIRST MIDDLE NICKNAME

Billing Address: _____
Street City State Zip

Social Security #: _____ Date of Birth: _____ Sex: _____

Race: _____ Language: _____ Hispanic or Latino? YES NO

Marital Status: _____ Primary Care Doctor: _____

Home Phone: _____ Cell Phone: _____ Confirmation: CALL OR TEXT

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Insurance Information:

Primary Insurance: _____ Circle One: Self Spouse Dependent

Card Holder Name: _____ Date of Birth: _____
Only if other than patient if other than patient

Secondary Insurance: _____ Circle One: Self Spouse Dependent

Card Holder Name: _____ Date of Birth: _____
Only if other than patient if other than patient

Authorization to Pay Benefits to Physician:

I hereby authorize payment directly to Cardiology Associates of Michigan, P.C. otherwise payable to me for services rendered. I understand the provider's charge may exceed the private insurance carrier payment. If the physician does not participate with my insurance I will be responsible for the difference. I also understand that the fees for any services performed that are not contact benefits will be my financial responsibility.

Authorization to Release information:

I hereby authorize Cardiology Associates of Michigan, P.C. to release any information necessary to process this claim.

_____

Signature (Patient or Guardian) **Date**

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Patient DOB:_____

HIPAA Notice and Acknowledgement

I, _____, acknowledge that I have received the attached notice of privacy practices. (Given upon request).

_____ _____
Patient or guardian signature Date

The following authorizations will remain in effect until revoked in writing by the patient or a patient's authorized personal representative.

In compliance with the privacy practices of cardiology associates of Michigan, P.C. I authorize Cardiology Associates of Michigan, P.C. and its agents to disclose and/or discuss my Private Health Information (PHI) with the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I authorize Cardiology Associates of Michigan, P.C. and its agents to leave messages regarding my PHI on a telephone answering machine or voicemail.

Please check the appropriate box:

- ☐ Yes
- ☐ Yes, with restrictions: _____
- ☐ No

_____ _____
Patient or Guardian Signature Date

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No-Show and Late Cancellation Policy

We are committed to providing exceptional medical care in a professional manner. When you schedule an appointment, time is reserved for your care, and clinicians and staff prepare for your visit. When an appointment is missed or canceled without sufficient notice, we are unable to offer that valuable time slot to another patient who needs medical care.

The following policy will become effective January 1, 2026

If you need to cancel or reschedule your appointment, we require a minimum of **24 hours' notice** prior to your scheduled appointment time. **For a Monday appointment**, please call by 3:00 PM on the preceding Friday.

Definition of a No-Show or Late Cancellation

An appointment will be considered a "no-show" or "late cancellation" if any of the following occur:

- You do not show up for your scheduled appointment.
- You cancel or reschedule your appointment with less than 24 hours' notice.
- You arrive more than 15 minutes after your scheduled appointment and, consequently, we are unable to accommodate you into the schedule.

Consequences of No-Shows and Late Cancellations

- **First Occurrence:** We understand that unexpected situations or emergencies can arise. A first-time occurrence may receive a courtesy waiver, and you will receive a warning letter and a reminder of our policy.
- **Subsequent Occurrence(s):** For all subsequent no-shows or late cancellations, a service charge of **$50** for all scheduled appointments and **$200** for nuclear stress tests will be billed directly to your account. This fee is the patient's sole responsibility and is not billable to or covered by your insurance company. **Payment of the no-show fee is required before scheduling any further appointments.**
- **After three (3)** no-shows or late cancellations within a 12-month period, you may be subject to dismissal from the practice.

Exceptions

We may waive the no-show fee in cases of genuine emergencies or extenuating circumstances (e.g., severe weather). Waiver determinations are at the sole discretion of Practice Management. Please contact us directly to discuss such situations.

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No-Show and Late Cancellation Policy

Patient Acknowledgment:

I have read and understand the No-Show and Late Cancellation Policy of Cardiology Associates of Michigan, P.C., adopted January 1, 2026. I agree with the terms and conditions, including the schedule of fees associated with the policy.

Patient Name (Print): _____

Signature: _____

Date: _____

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Patient Name: _____ DOB: _____ Sex: _____

Pharmacy: _____ Pharmacy Phone #: _____ Pharmacy Zip Code: _____

Reason For Visit: (Please Write)
_____
_____

Allergies and Reactions (List any medications or food including IV dye, shellfish, or seafood):

Allergy:	Reaction:

CARDIAC RISK FACTORS:

TOBACCO USE: ☐ Vaping Type: _____ Years used: _____
☐ Current Units/Packs per day: _____ Year quit: _____
☐ Former
☐ Never Passive smoke exposure? ☐ Yes ☐ No

ALCOHOL USE:
☐ Current
☐ Former Year Quit: _____
☐ Never
☐ Daily
☐ Occasionally
☐ Socially
☐ Never

DRUG USE: Type: _____
☐ Current
☐ Former Year Quit: _____
☐ Never
☐ Daily ☐ IV
☐ Occasionally ☐ Oral
☐ Socially ☐ Smoked
☐ Never ☐ Snorted

Diabetes: ☐ Yes ☐ No If yes, what type? ☐ Type 1 (Juvenile) ☐ Type 2 (Adult onset)

Family History: Has any family member ever been diagnosed with heart disease before the age of 65? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following?

Peripheral Valve Disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Dyslipidemia	☐ Yes	☐ No

Forwarding Documents: Please list the names of any physicians you would like records sent to:

Physician: _____ City/State: _____ Phone Number: _____

Physician: _____ City/State: _____ Phone Number: _____

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Patient Name: _____

Past Medical History: Please check any of the following that you currently HAVE or HAD

HEENT:
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Headache/Migraine
- ☐ Macular Degeneration

Endocrine:
- ☐ Goiter
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Gastrointestinal:
- ☐ Barrett's Esophagus
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ GERD/Reflux
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Ischemic Bowel
- ☐ Lower GI Bleed
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease

Hematology:
- ☐ Anemia

Infectious Disease:
- ☐ AIDS
- ☐ Endocarditis
- ☐ Hepatitis
- ☐ HIV
- ☐ Lyme Disease
- ☐ MRSA
- ☐ Pelvic Inflammatory Disease
- ☐ Pneumonia
- ☐ Tuberculosis

Musculoskeletal:
- ☐ Back Pain
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Herniated Disk
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Spinal Stenosis

Neurologic:
- ☐ Alzheimer's Disease
- ☐ CVA (Stroke)
- ☐ Dementia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Syncope
- ☐ TIA (Mini Stroke):

OBGYN:
- ☐ Gestational Diabetes
- ☐ Pre Eclampsia
- ☐ Eclampsia
- ☐ Currently Pregnant

only if yes how far along? _____

Oncology:
- ☐ Cancer: Type_____

Psychiatric:
- ☐ Anorexia
- ☐ Mood Disorders
- ☐ Bulimia
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Disorder
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia

Renal/ Genitourinary:
- ☐ End Stage Renal Disease
- ☐ Erectile Dysfunction
- ☐ Hematuria
- ☐ Kidney Stones
- ☐ Polycystic Kidneys
- ☐ Renal Artery Stenosis
- ☐ Renal Failure, Acute
- ☐ Renal Insufficiency

Respiratory:
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Pulmonary Embolus
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea

Skin:
- ☐ Cellulitis

Vascular:
- ☐ Claudication
- ☐ DVT
- ☐ Peripheral Vascular Disease
- ☐ Reynaud's
- ☐ Varicose Veins

Cardiac:
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Edema
- ☐ CAD
- ☐ Arrhythmia
- ☐ Implantable Device
- ☐ Cardiomyopathy
- ☐ Congenital Heart Disease

Other/Not Listed:

Past Surgical History: Please list any surgeries you have had and any additional information, If possible.

Surgery:	Location:	Date:

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Patient Name: _____

Family History:

Relationship:	Age:	Significant Health Problem	Cause of Death

Review of Symptoms: Please check the box if you are experiencing any of the symptoms listed below

☐ Chest Pain, pressure or tightness	☐ Shortness of breath with rest
☐ Heart palpitations or irregular heartbeats	☐ Shortness of breath with activity
☐ Excessive Sweating	☐ Use of multiple pillows at night
☐ Fainting or feeling of fainting	☐ Nausea
☐ Shortness of breath while laying flat	☐ Heartburn, reflux or indigestion
☐ Waking up at night feeling short of breath	☐ Rectal Bleeding
☐ Pain in legs while walking	☐ Blood in urine
☐ Swelling in hands, feet or ankles	☐ Frequent urination at night
☐ Weight gain	☐ Dizziness
☐ Weight loss	☐ Loss of memory
☐ Fevers	☐ Seizures
☐ Fatigue	☐ Depression
☐ Vision changes	☐ Hallucinations
☐ Hearing loss	☐ Bleeding easily
☐ Snoring	☐ Bruising easily

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MEDICATION LIST

DATE: ____________________ DOB: ____________________

PATIENT NAME: ____

MEDICATION NAME:	DOSAGE:	FREQUENCY