Providence Heart Institute

Spokane Cardiology
Tel: 509-455-8820 or 1-877-455-8820

Welcome to Providence Spokane Cardiology
On behalf of the entire staff, we would like to welcome you. We look forward to providing an office environment and provider relationship that meets you and/or your family's cardiac needs.

Providence Spokane Cardiology has 39 providers and continues to grow. To help serve our patients and communities, we have clinics in five different locations. We pride ourselves in knowing your care will be monitored by our team of Cardiologists and Advanced Practice Providers (APPs). Our APPs and their advanced training in Cardiovascular Disease has allowed us to handle our patients care with a team approach. Our APPs collaborate with our Cardiologists to provide the best care to our patients in a variety of clinical settings. Your consultation may be scheduled with one of our APPs, this not only extends your support by the APP but it also allows more patient's access to a Cardiology consult. Routine visits in general rotate between the APP and your assigned Cardiologist. Because our APPs work alongside a Cardiologist, they are able and willing to seek assistance if your problem requires more in-depth care. Our goal is to provide you with outstanding service.

Your trust in our knowledge and expertise is very important to us.

<u>The day of your appointment</u>

- Copay or deposit amount is due at the time of service (We DO NOT accept cash or check)
- Bring your insurance card(s) and photo ID
- Bring all non-narcotic medications in their **original containers** and a list of your narcotic medications ○ Please **do not** bring in any of your narcotic medications with you.

If you need to cancel or reschedule your appointment, please give us **24 hours**' notice

- Call 509-455-8820 or 1-877-455-8820 Monday-Friday 730am-500pm - Option 3 for Scheduling

Enclosed are our patient registration forms. Please complete these forms to the best of your knowledge and bring with you on the day of your appointment.

- Your Scheduled Appointment Date, Time, and Location
- MyChart Information Pamphlet
- Narcotic and Allergy List

We look forward to meeting you.

Sincerely,
The Spokane Cardiology Group

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Scheduled Appointment(s)

Thank you for taking the time to schedule with us, below you will find your scheduled appointment(s) date, time, and location. If you need to cancel or reschedule your appointment, please give us **24 hours**' notice.

1st Scheduled Appointment

For a(n): _____ With: _____

Date: _____ Arrival Time: _____

☐ **Spokane Heart Institute**
62 West 7th Ave Ste. _____
Spokane WA, 99204

☐ **Holy Family Medical Building**
212 East Central Ste. 240
Spokane, WA 99208

☐ **Clarkston Office**
808 Port Drive
Clarkston, WA 99403

☐ **Spokane Heart Institute – Diagnostics**
62 West 7th Ave Ste. 230
Spokane WA, 99204

☐ **Spokane Cardiology Outreach Clinic**
_____

☐ **Providence Medical Park**
16528 East Desmet Ct. Ste. B3200
Spokane Valley, WA 99216

☐ **Holy Family Medical Building – Diagnostics**
212 East Central Ave, Spokane, WA 99208
*Check in at the MAIN ADMITTING desk on the 1st floor

2nd Scheduled Appointment

For a(n): _____ With: _____

Date: _____ Arrival Time: _____

☐ **Spokane Heart Institute**
62 West 7th Ave Ste. _____
Spokane WA, 99204

☐ **Holy Family Medical Building**
212 East Central Ste. 240
Spokane, WA 99208

☐ **Clarkston Office**
808 Port Drive
Clarkston, WA 99403

☐ **Spokane Heart Institute – Diagnostics**
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Narcotic and Allergy List

Please complete to the best of your knowledge.

Patient Name: _____ _____ D.O.B: _____

(First) (Last)

Please list all narcotic medications (Codeine, Hydrocodone, Oxycodone, etc.). Only bring non-narcotic prescriptions, over the counter medications and herbal or supplements to your appointment in their original containers.

Narcotic List Name	Dose	When is it taken	Route
▪ _____	_____		
▪ _____	_____		
▪ _____	_____		
▪ _____	_____		
▪ _____	_____		
▪ _____	_____		

DO NOT BRING ANY NAROTIC MEDICATIONS TO YOUR APPOINTMENT! All other medications should be with you at time of appointment in the original bottles

Please list any known medication allergies.

Medication Allergies	Reaction
▪ _____	_____
▪ _____	_____
▪ _____	_____
▪ _____	_____
▪ _____	_____
▪ _____	_____

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Office Policies and Expectations

Please review and initial indicating you have read and understand our office policies and expectations

First Name: _____Last Name:_____ D.O.B: _____ Date:_____

_____*initials* **Financial Policy**

We recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship.

- Make sure you have a good understanding of what is and is not covered by your insurance plan
  - You can contact our billing office **1-866-747-2455** with questions regarding fees or financial responsibilities.
- Co-pays are due at the time of service
  - We accept VISA, MasterCard, Discover and American Express
- Self-pay patients are required to pay a deposit at the time of service
  - **$75.00** New Patient and **$50.00** Established Patient
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage.
  - If necessary, please make sure your referring provider has obtained any necessary prior authorization or referral required by your insurance company.
- If we are contracted with your insurance, we will bill your insurance company first, then bill you for any amount determined to be your responsibility.
- Any procedures, lab work, diagnostics, etc that you have completed outside of this office or that is sent for interpretation, is not included in the charge for your office visit(s). You will receive a separate bill for those charges directly from the facility providing the service.

_____*initials* **No-Show Policy**

As a courtesy to all our patients, you will receive a reminder call two business day prior to your scheduled appointment with the date and time. Recognizing that everyone's time is valuable, and that appointment time is limited, we ask that you provide us **24-hours' notice** if you are unable to keep your scheduled appointment. Appointments canceled with less than 24 hours' notice will receive a letter.

To improve care for our patient, we will track "No-Show" activity. All **new patients** are allowed to miss one scheduled appointment without penalty. Once a second appointment is missed, the patient will be discharged from the practice and their referring provider will be notified. All **established patients** will be allowed to miss two scheduled appointments without penalty. Once the third appointment is missed, the patient will be at risk of being discharged from the practice. To prevent this from happening, patients will receive a letter when they no-show their scheduled appointment.

A no-show is defined as below:

- An appointment which is missed by the patient without any advance notice.

_____*initials* **RX Refill Policy**

Please contact your pharmacy directly for all prescription refills. We require **48 hours' notice** for all prescription refills. If you have requested a refill and it's been longer than 48 hours, please feel free to call us.