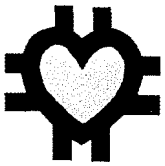

Eastern Shore
Heart Center

Comprehensive heart care with a personal touch

Craig Peterson, MD, FACC
Double Board Certified
Internal Medicine, American Board of Internal Medicine
Cardiovascular Disease, American Board of Internal Medicine

19725 So. Greeno Rd.
Fairhope, AL 36532
(251) 990-1930
Fax: (251) 990-1931

PATIENT REGISTRATION

DATE:_____

LAST NAME:_____ FIRST NAME:_____ MIDDLE NAME:_____

DATE OF BIRTH:_____SOCIAL SECURITY #:_____SEX:_____ MARITAL STATUS:_____

STREET ADDRESS:_____CITY/STATE/ZIP:_____

HOME PHONE:_____DAYTIME PHONE:_____CELL PHONE:_____

EMAIL ADDRESS:_____PREFERRED COMMUNICATION METHOD:_____

PATIENT EMPLOYER:_____ADDRESS:_____PHONE:_____

EMERGENCY CONTACT NAME/RELATIONSHIP_____PHONE:_____

REFFERING PHYSICIAN:_____ADDRESS:_____PHONE:_____

REFERRAL SOURCE:_____

PRIMARY INSURANCE
CARRIER:_____ADDRESS:_____

INSURED NAME:_____DOB:_____PATIENT RELATIONSHIP:_____

INSURED I.D.:_____GROUP#:_____

SECONDARY INSURANCE
CARRIER:_____ADDRESS:_____

INSURED NAME:_____DOB:_____PATIENT RELATIONSHIP:_____

INSURED I.D.#:_____GROUP#:_____

EASTERN SHORE HEART CENTER
19725 SOUTH GREENO RD.
FAIRHOPE, AL. 36532

CONSENT FORM

I HEREBY give my consent for treatment and any testing procedures by Eastern Shore Heart Center's physician and/or clinical staff members. I authorize the release of my medical information to any providers involved in the direct care associated with my treatment.

FINANCIAL AUTHORIZATION

I HEREBY acknowledge that the patient or responsible party is financially responsible for payment of the account regardless of whether they do or do not have insurance. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fees including any/all of collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under laws of the constitution of the State of Alabama, and any other State.

PRINT NAME _____ ACCOUNT/RECORD NUMBER _____

SIGNATURE _____ DATE _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE – HIPAA

I HEREBY acknowledge I have been notified & my rights are displayed and available for review of the Notice of Privacy Practice.

INSURANCE AUTHORIZATION/RELEASE OF MEDICAL INFORMATION

I HEREBY authorize the release of medical information to insurance carriers necessary to process claims and hereby assign to Eastern Shore Heart Center all payments for medical services rendered. I hereby authorize and direct my insurance carrier (s), including Medicare, private insurance and any other health/medical plan, to issue payment (s) directly to Eastern Shore Herat Center, for medical services/supplies rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am personally responsible for any amount not covered by this insurance assignment.

SIGNATURE _____ DATE

EASTERN SHORE HEART CENTER

PAGE TWO CONSENT FORM

PATIENT NAME:_____ _____
ACCOUNT /RECORD NUMBER

CONSENT TO CONTACT

I hereby AGREE, in order for us to service your account or to collect monies you may owe, remind you of appointments, Eastern Shore Heart Center and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by leaving voice messages, sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Eastern Shore Heart Center, its employees and/or agents may contact me/us as described above.

Patient Signature _____ Date _____

Printed Name of Patient_____

_____

It patient is unable to sign, responsible party signature and relationship **Date**

FOR OFFICE USE ONLY: In lieu of patient signature, I _____
an employee of ESHC state that patient, _____, has been given our current Notice of Privacy Practices. Please initial _____if patient refused to sign.

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Craig Peterson, MD, FACC
19725 So. Greeno Rd.
Fairhope, AL 36532
(251) 990-1930
Fax: (251) 990-1931

This is an authorization giving Eastern Shore Heart Center, Craig R. Peterson, M.D. and staff permission to have verbal or written communication with your spouse, family members and/or someone specified by you regarding your medical condition, treatment and/or financial matters concerning your treatment. Please list below individuals who may receive information by any type of communication.

I, _____ , give permission to release information to the following:

PRINT NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature Date

_____ _____
Witness Date

EASTERN SHORE HEART CENTER

Nuclear Stress Test

Someone from our office will call the day before the test to confirm you will be here.

We ONLY order the tracer if your appointment has been confirmed verbally the day before.

The dosage is timed and ordered the evening before your test. We must have 24 hour notice if you are unable to keep this appointment.

What is a Nuclear Stress Test?

A nuclear stress test is a test used to evaluate the blood flow through the coronary arteries into the muscle of the heart. With the use of a small amount of a radioactive tracer and a special type of radiation detection camera, the cardiologist is able to evaluate the blood flow by reviewing a set of images demonstrating the distribution of the radiotracer within the muscle of the heart.

How is the test done?

The test is generally done in two phases: 1. Resting phase 2. Stressed phase. Each phase requires an injection of the radiotracer followed by a set of images of the heart in order to demonstrate the distribution of the tracer at the time of the injection.

The Nuclear Medicine Technologist (an individual trained in the field of nuclear medicine) will start an I.V., either on the back of the hand or at the bend of the elbow. This I.V. access allows for the injection of the radioactive tracer.

The first phase injection is made with the heart at a "resting" state with a set of images taken 30-45 minutes after the injection. The second phase injection is made during the physical treadmill stress test or a chemical drug induced non-physical stress test. The cardiologist will determine the type of stress test that is best for you. In cases where patients are unable to achieve adequate exercise on the treadmill, the chemical stress test is sometimes the test of choice. After the stress test, a second set of images is taken, usually 15 minutes to one hour after injection of the tracer. Depending on the study, each set of images takes between 12 to 17 minutes in a sitting position. The main point to emphasize is that it is very important to be extremely still while the camera takes the images.

What is the preparation for the test?

1. ***We ask that you eat a light meal ONLY (toast, oatmeal, cereal, juice and/or water).***
   ABSOLUTELY NO COFFEE OR TEA including decaf or any foods containing caffeine, like chocolates, 12 hours prior to the test.
2. **Do not take your morning medicines, unless instructed to do so, but do bring them with you. You may take medicine as soon as the test is complete.**
3. **Wear comfortable clothing, walking or tennis shoes.**
4. **If you use inhalers for asthma or lung disease, bring them with you.**
5. **SOMEONE FROM THE OFFICE WILL CALL THE DAY BEFORE TO CONFIRM.**

How long does the test take?

Plan to spend two to three hours with us to complete the test.