HEARTFIT FOR DUTY

heartfitforduty.org

Protecting Our First Responders

Date: _____

Personal Information		
Last Name:	First Name:	M.I.
Address:		
City:	State:	Zip:
Phone:	D.O.B.	Age:
Gender: ☐ M ☐ F	Height: _____ft. _____in.	Weight: _____Lbs._____

Employer Information	
Employer:	Hire Date:
Employment Status (FT, PT, Volunteer):	Employer Phone:
Employee ID #:	Rank/ Title:

Emergency Notification Contact Information		
Name:		
Relationship:		
Contact Phone 1:	Contact Phone 2:	
Address:		
City:	State:	Zip:

Primary Care Physician Information		
Primary Care Physician or Group:		
Phone:	Fax:	
Office Address:		
City:	State:	Zip:

HeartFit For Duty
5432 E. Southern Ave
#101
Mesa, AZ 85206
Phone: **480-999-7911**
Fax: **480-499-5829**

Patient Name:_____

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: ☐ Yes ☐ No
2. Have you *ever had* any of the following conditions?
    a. Seizures: ☐ Yes ☐ No
    b. Diabetes (sugar disease): ☐ Yes ☐ No
    c. Allergic reactions that interfere with your breathing: ☐Yes ☐ No
    d. Claustrophobia (fear of closed-in places): ☐ Yes ☐ No
    e. Trouble smelling odors: ☐ Yes ☐ No
3. Have you *ever had* any of the following pulmonary or lung problems?
    a. Asbestosis: ☐ Yes ☐ No
    b. Asthma: ☐ Yes ☐ No
    c. Chronic bronchitis: ☐ Yes ☐ No
    d. Emphysema: ☐ Yes ☐ No
    e. Pneumonia: ☐ Yes ☐ No
    f. Tuberculosis: ☐ Yes ☐ No
    g. Silicosis: ☐ Yes ☐ No
    h. Pneumothorax (collapsed lung): ☐ Yes ☐ No
    i. Lung cancer: ☐ Yes ☐ No
    j. Broken ribs: ☐ Yes ☐ No
    k. Any chest injuries or surgeries: ☐ Yes ☐ No
    l. Any other lung problem that you've been told about: ☐ Yes ☐ No
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
    a. Shortness of breath: ☐ Yes ☐ No

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b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:

☐ Yes ☐ No

c. Shortness of breath when walking with other people at an ordinary pace on level ground:

☐ Yes ☐ No

d. Have to stop for breath when walking at your own pace on level ground: ☐ Yes ☐ No

e. Shortness of breath when washing or dressing yourself: ☐ Yes ☐ No

f. Shortness of breath that interferes with your job: ☐ Yes ☐ No

g. Coughing that produces phlegm (thick sputum): ☐ Yes ☐ No

h. Coughing that wakes you early in the morning: ☐ Yes ☐ No

i. Coughing that occurs mostly when you are lying down: ☐ Yes ☐ No

j. Coughing up blood in the last month: ☐ Yes ☐ No

k. Wheezing: ☐ Yes ☐ No

l. Wheezing that interferes with your job: ☐ Yes ☐ No

m. Chest pain when you breathe deeply: ☐ Yes ☐ No

n. Any other symptoms that you think may be related to lung problems: ☐ Yes ☐ No

5. Have you *ever had* any of the following cardiovascular or heart problems?

a. Heart attack: ☐ Yes ☐ No

b. Stroke: ☐ Yes ☐ No

c. Angina: ☐ Yes ☐ No

d. Heart failure: ☐ Yes ☐ No

e. Swelling in your legs or feet (not caused by walking): ☐ Yes ☐ No

f. Heart arrhythmia (heart beating irregularly): ☐ Yes ☐ No

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g. High blood pressure: ☐ Yes ☐ No

h. Any other heart problem that you've been told about: ☐ Yes ☐ No

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: ☐ Yes ☐ No

b. Pain or tightness in your chest during physical activity: ☐ Yes ☐ No

c. Pain or tightness in your chest that interferes with your job: ☐ Yes ☐ No

d. In the past two years, have you noticed your heart skipping or missing a beat: ☐ Yes ☐ No

e. Heartburn or indigestion that is not related to eating: ☐ Yes ☐ No

f. Any other symptoms that you think may be related to heart or circulation problems:

☐ Yes ☐ No

7. Do you *currently* take medication for any of the following problems?

a. Breathing or lung problems: ☐ Yes ☐ No

b. Heart trouble: ☐ Yes ☐ No

c. Blood pressure: ☐ Yes ☐ No

d. Seizures: ☐ Yes ☐ No

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9)

a. Eye irritation: ☐ Yes ☐ No

b. Skin allergies or rashes: ☐ Yes ☐ No

c. Anxiety: ☐ Yes ☐ No

d. General weakness or fatigue: ☐ Yes ☐ No

e. Any other problem that interferes with your use of a respirator: ☐ Yes ☐ No

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Questions 9 to 14 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

9. Have you *ever lost* vision in either eye (temporarily or permanently): ☐ Yes ☐ No
10. Do you *currently* have any of the following vision problems?
    a. Wear contact lenses: ☐ Yes ☐ No
    b. Wear glasses: ☐ Yes ☐ No
    c. Color blind: ☐ Yes ☐ No
    d. Any other eye or vision problem: ☐ Yes ☐ No
11. Have you *ever had* an injury to your ears, including a broken ear drum: ☐ Yes ☐ No
12. Do you *currently* have any of the following hearing problems?
    a. Difficulty hearing: ☐ Yes ☐ No
    b. Wear a hearing aid: ☐ Yes ☐ No
    c. Any other hearing or ear problem: ☐ Yes ☐ No
13. Have you *ever had* a back injury: ☐ Yes ☐ No
14. Do you *currently* have any of the following musculoskeletal problems?
    a. Weakness in any of your arms, hands, legs, or feet: ☐ Yes ☐ No
    b. Back pain: ☐ Yes ☐ No
    c. Difficulty fully moving your arms and legs: ☐ Yes ☐ No
    d. Pain or stiffness when you lean forward or backward at the waist: ☐ Yes ☐ No
    e. Difficulty fully moving your head up or down: ☐ Yes ☐ No
    f. Difficulty fully moving your head side to side: ☐ Yes ☐ No

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g. Difficulty bending at your knees: ☐ Yes ☐ No

h. Difficulty squatting to the ground: ☐ Yes ☐ No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: ☐ Yes ☐ No

j. Any other muscle or skeletal problem that interferes with using a respirator: ☐ Yes ☐ No

15. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals:

☐ Yes ☐ No

a. If "yes," name the chemicals if you know them: _____

_____

16. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: ☐ Yes ☐ No

b. Silica (*e.g.*, in sandblasting): ☐ Yes ☐ No

c. Tungsten/cobalt (e.g., grinding or welding this material): ☐ Yes ☐ No

d. Beryllium: ☐ Yes ☐ No

e. Aluminum: ☐ Yes ☐ No

f. Coal (for example, mining): ☐ Yes ☐ No

g. Iron: ☐ Yes ☐ No

h. Tin: ☐ Yes ☐ No

i. Dusty environments: ☐ Yes ☐ No

j. Any other hazardous exposures: ☐ Yes ☐ No

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i. If "yes" answered to any of the above, describe the exposure(s):

_____

_____

17. List any second jobs or side businesses you have: _____

_____

18. List your previous occupations: _____

_____

19. List your current and previous hobbies: _____

_____

20. Have you been in the military services? ☐ Yes ☐ No

a. If "yes," were you exposed to biological or chemical agents (either in training or combat):

☐ Yes ☐ No

21. Have you ever worked on a HAZMAT team? ☐ Yes ☐ No

22. Alcohol Use: ☐ Yes ☐ No

a. How many beers do you drink each week? _____

b. How many bottles of wine per week? _____

c. How many drinks of liquor per week? _____

23. Tobacco Current Use: ☐ Yes ☐ No

a. Do you currently use tobacco?

b. How many of the following do you smoke or chew per day?

i. Cigarettes _____ Packs/day x _____years

ii. Chew _____ Cans/day x _____years

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24. Tobacco Past Use: ☐ Yes ☐ No

    a. Have you used tobacco in the past? ☐ Yes ☐ No

    b. How many of the following do you smoke or chew per day?

        i. Cigarettes _____ Packs/day x _____years

        ii. Chew _____ Cans/day x _____years

        iii. Quit Date: _____

25. Fitness Review:

    a. Please list your exercise activities and number of times per week you perform each.

        i. Aerobic _____x week

        ii. Weight Training _____x week

        iii. Other: _____

    b. Since your last exam, compare your activity level: ___ More ___ Less ___ Same

26. Occupational Exposures: ☐ Yes ☐ No

    a. Have you had any work related exposures to fires or HazMat situations where you have developed health changes? ☐ Yes ☐ No

        i. If yes, please describe:_____

    b. Other Work Related Health Problems (since last exam)

        i. Occupational Injuries/Illnesses: _____

        ii. Diagnosis: _____Time Lost:_____

    c. Are you a member of the Hazardous Materials Team? ☐ Yes ☐ No

        i. If yes, have you had any exposures in the last year? ☐ Yes ☐ No

    d. Are you a member of the FEMA (AZ Task Force-1) team? ☐ Yes ☐ No

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i. If yes, have you been on a deployment in the last year? ☐ Yes ☐ No

27. Recreational / Hobbies Review: ☐ Yes ☐ No

a. Are you finding your hobbies and recreation less enjoyable? ☐ Yes ☐ No

b. Do you feel fatigued even if you have not been physically active? ☐ Yes ☐ No

c. Are you worrying more than usual? ☐ Yes ☐ No

d. Are you more irritable than usual around family or co-workers? ☐ Yes ☐ No

e. List your hobbies (i.e. woodworking, stained glass, etc) and number of times per week you perform them:

i. _____x week_____

ii. _____x week_____

iii. _____ x week_____

iv. _____x week_____

f. Do you use any chemicals or other materials in your hobbies such as solvents, solder, pesticides, lead, or other materials? ☐ Yes ☐ No

i. If yes, please describe chemicals involved:_____

28. Medication Review:

a. Are you currently taking, or have you taken any of the following within the past month?

☐ Antacids
☐ Antibiotics
☐ Anticoagulants (blood thinners)
☐ Antidepressants
☐ Antihistamines
☐ Anti-inflammatory
☐ Appetite suppressants
☐ Aspirin
☐ Blood pressure pills
☐ Codeine
☐ Cortisone or Steroids
☐ Digitalis
☐ Diuretic (water pills)
☐ Hormones
☐ Insulin/oral diabetic drug
☐ Laxatives
☐ Sleeping pills
☐ Testosterone/Anabolic Steroid
☐ Thyroid
☐ Tranquilizers
☐ Tylenol
☐ Vitamins/Supplements

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b. List any drugs (by name) you take regularly and the dosage used:

_____

_____

29. Since your last exam, have you developed any allergies? ☐ Yes ☐ No

    a. If yes, please describe _____

30. Since your last exam, have you had any difficulties having children? (i.e. infertility, miscarriage, spontaneous abortion) ☐ Yes ☐ No ☐ N/A

    a. If yes, please describe: _____

31. Since your last exam, have you had any health changes or problems? ☐ Yes ☐ No

    a. If yes, please describe:

_____

_____

32. Since your last exam, have you been hospitalized? ☐ Yes ☐ No

    a. If yes, please describe:_____

33. Since your last exam, have you had any surgery(s)? ☐ Yes ☐ No

    a. If yes, please describe (give dates and reasons):

_____

_____

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Signed Documents

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all charges submitted by this office during the course of treatment for the patient. I agree to pay all applicable co-payments, co-insurance, and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be covered service by my insurer and/or a third party insurer or other payor. I further understand that if I do not show for an appointment or do not give 24 hours notice to HeartFit For Duty when cancelling an appointment I may be responsible for charges up to the potential cost of the visit.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the hereby authorize HeartFit For Duty and its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, and other healthcare providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to HeartFit for Duty for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

CONFIDENTIALITY

In order to receive the course of evaluation and treatment offered by HeartFit For Duty, the Patient will be exposed to certain information about the processes, testing, and strategies implemented by HeartFit For Duty. The company considers such information to be proprietary and confidential and is willing to evaluate, treat, and disclose such information to, Patient only upon receipt of the agreement of the Patient to comply with the provisions hereof. "Confidential Information" shall mean all information about HeartFit For Duty which is furnished by it or any of its representatives to Patient, and includes, without limitation, all information regarding the business and affairs of HeartFit For Duty, its operations, testing processes, analytical methods, business partners, media and/or presentations, educational or informational material, analyses, compilations, forecasts, studies, procedures, formulae, improvements, trade secrets or other proprietary documents or information prepared or furnished by HeartFit For Duty, that has been previously or may hereafter be disclosed in any form, whether in writing, orally, electronically, or otherwise, or otherwise made available by observation, inspection, or otherwise by the HeartFit for Duty, or its affiliates or representatives. Confidential Information shall not include test results, medical reports or records generated by HeartFit For Duty which are personal to the Patient and which would normally be used in Patient's further health evaluations and treatment.

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Unless otherwise agreed to in writing by HeartFit for Duty, the patient agrees to keep confidential all Confidential Information and not to disclose or reveal any Confidential Information to any person other than Patient's personal physician(s) or doctor(s) for the sole purpose of Patient's further health evaluations and treatment. Patient further agrees not to use Confidential Information for any purpose other that in connection with Patient's further health evaluations and treatment, including without limitation, to engage or participate, or aid another in engaging or participating, in any venture or business which would directly or indirectly compete with the services offered by HeartFit For Duty in the normal course of business.

FINANCIAL POLICIES

Thank you for choosing to seek services with HeartFit For Duty.
We are committed to providing excellent healthcare service to our patients. As part of our professional relationship it is important that you understand our financial policy.

It is your responsibility to provide us with your most current insurance and billing information.
Co-payments, co-insurance, and deductibles are due at time of service.
For co-insurance and deductibles we will estimate the amount you owe. You will be responsible for the balance after your insurance company pays your claim.

We accept cash, checks, Visa, And MasterCard.
You will receive a statement from our billing office for any balance due.
Payment for your balance will be due upon receipt of the statement. If you are unable to pay the balance in full, you must contact our office to make payment arrangements.

****IT IS YOUR RESPONSIBILTY TO BE AWARE OF YOUR INSURANCE BENEFITS.****

If we are the preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information you provide. However, the agreement of the insurance company to pay for medical care is between you and your carrier.

Please present your card with each visit.

If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen.

Delinquent accounts over 60-days shall be sent to collections for processing, at which point all collection fees, contingent or not, shall be added to the patient's responsibility. In the event, legal action is required, the patient shall be responsible for all reasonable attorney's fees and costs.

If your check is returned due to insufficient funds you will be charges an additional $35.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I HAVE READ AND I UNDERSTAND THE ABOVE POLICIES AND I AGREE TO ABIDE BY ALL TERMS.

Patient Signature		Date	

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Authorization to Receive Medical Records

I authorize the release of my entire medical records by the organization or physician listed below:

PREVIOUS PHYSICIAN INFORMATION

Physician Name		Practice	
Phone #		Fax#	

PATIENT INFORMATION

Patient Name		DOB	
Phone #		SSN#	

PLEASE FAX ENTIRE MEDICAL RECORDS TO: 855-372-1670

Disclaimer:

The medical records or medical information are requested for the purpose of continuing my medical care and treatment. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present any written revocation to the medical records department. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless I specify differently, this authorization will expire six-months from the date signed below. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the information may not be protected by federal privacy laws or regulations. I understand that the use or disclosure if the information identified above is voluntary, I need not sign this form to insure healthcare treatment.

HIV/AIDS:	I consent to the release of any positive or negative test results of AIDS or HIV infection, antibodies to HIV/AIDS, or infection with any other causative agent of AIDS with the rest of my medical record.	☐ Yes ☐ No

Patient Signature		Date	
Legal Representative		Relationship	

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