



Please complete the following items below and bring to your first appointment

Complete the forms listed below:

- Admission Data Sheet
 - Informed Consent
 - Medical Record Release
 - Vocational Rehab Screen
 - Medication List
 - Psychosocial Assessment Forms
 - Cardiac Quiz
 - Nutrition Assessment Forms
- Call insurance company to confirm coverage and if pre-authorization is required for Phase 2 Cardiac Rehabilitation.
 - If applicable, complete the Patient Financial Services Forms, call and set up time to talk with a representative in the financial services office. (336-538-8400).
 - Get ready for a great experience. Please call 336-538-8120 with any questions.

HeartTrack Cardiac Rehabilitation

Consent to Participate

Name: _____

1. Purpose and Explanation of Procedure

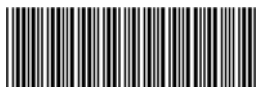
In order to improve my physical capacity and generally aid in my medical treatment for heart disease, I hereby consent to enter a cardiac rehabilitation program that will include cardiovascular monitoring, physical exercise, dietary counseling, smoking cessation, stress reduction, and health education activities. The levels of exercise that I will perform will be based on the condition of my heart and circulation as determined by my physician. I will be given instructions regarding the amount and kind of exercise I should do. I agree to participate up to three times per week in the rehabilitation program. Professionally trained clinical personnel will provide leadership to direct my activities and may monitor my electrocardiogram and blood pressure to be certain that I am exercising at the prescribed level. I understand that I am expected to attend every session and to follow physician and staff instructions with regard to any medications that may have been prescribed, exercise, diet, stress management, and smoking cessation. If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes my doctor or I have made with regard to use of these.

I have been informed that in the course of my participation in exercise, I will be asked to complete the activities unless such symptoms as fatigue, shortness of breath, chest discomfort, or similar occurrences appear. At that point, I have been advised that it is my complete right to stop exercise and that it is my obligation to inform the program personnel of my symptoms. I recognize and hereby state that I have been advised that I should immediately upon experiencing any such symptoms inform the program personnel of my symptoms.

I understand that during the performance of exercise, a trained observer will periodically monitor my performance and perhaps take my electrocardiogram, pulse, blood pressure, or make other observations for the purpose of monitoring my progress and/or condition. I also understand that the observer may reduce or stop my exercise program when findings indicate that this should be done for my safety and benefit.

2. Risks

It is my understanding, and I have been informed, that there exists the possibility during exercise of adverse changes including abnormal blood pressure; fainting; disorders of heart rhythm; and very rare instances of heart attack, stroke, or even death. Every effort, I have been told will be made to minimize these occurrences through risk



stratification, proper staff assessment of my condition before each exercise session, staff supervision during exercise, and my own careful control of exercise effort. I have also been informed that emergency equipment and personnel are readily available to deal with unusual situations should these occur. I understand that there is a risk of injury, heart attack, stroke, or even death as a result of my exercise, but knowing those risks, it is my desire to participate as herein indicated.

3. Benefits to Be Expected and Alternatives Available to Exercise

I understand that this medical treatment may or may not benefit my health status or physical fitness. Generally, participation will help determine what recreational and occupational activities I can safely and comfortably perform at home or on my own. Many individuals in such programs also show improvements in their capacity for physical work. For those who are overweight and able to follow the physician's and dietitian's recommended dietary plan, this program may also aid in achieving appropriate weight reduction and control.

4. Confidentiality and Use of Information

I have been informed that the information obtained from this rehabilitation program will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent. I do, however, agree to the use of any information for research and statistical purposes as long as it does not identify my person or provide facts that could lead to my identification. I also understand that this is a group program, which may require blood pressure and heart rate readings during class, as well as telemetry monitoring which will display heart rhythms with participant's first

name only as ID. I release the right of patient confidentiality for these procedures during class. I also consent to the use of colored charts to identify specific class type participation. I reserve the right to change my mind and request that all my information remains confidential. Only the program staff in the course of prescribing exercise for me, planning my rehabilitation program, or advising my personal physician of my progress, however, will use any other information obtained. I also understand that information collected may be discussed in a case conference format that includes all care providers.

5. Inquiries and Freedom of Consent

I have been given an opportunity to ask questions as to the procedures of this program.

I further understand that there are remote risks other than those previously described that may be associated with this program. Despite the fact that a complete accounting of all remote risks is not entirely possible, I am satisfied with the review of these risks that was provided to me, and it is still my desire to participate.

I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read this document.

I consent to the performance of all services and procedures as explained herein by all program personnel.

Patient's Signature	Date	Time (am/pm)
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Witness's Signature	Date	Time (am/pm)
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Program Staff Signature	Date	Time (am/pm)
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HeartTrack Cardiac Rehabilitation Medical Records Release

I authorize the release of the items below. I understand these records will only be used to aid in my treatment, and will not be released to any person or agency without my authorization.

Records should be post event (i.e. CABG, PCI, MI, hospitalization). Please send all that apply to the following patient

_____ DOB: _____

- _____ Stress test
- _____ Discharge summary
- _____ Medical history
- _____ Lipid panel (most recent)
- _____ Catheterization report
- _____ Operative report
- _____ EKG (most recent)

Please send/fax records to:
HeartTrack Cardiac Rehabilitation
Alamance Regional Medical Center
P.O. Box 202
Burlington, N.C. 27216
Phone: 336-538-8120
Fax: 336-538-7529

Signature

Printed name

Date: _____

Time: _____ am/pm



Heart Track Cardiac Rehabilitation Admission Data

Please complete the following information to the best of your ability. This information will help us formulate your plan of care. If you have any questions, please call us at 538-8120, or bring a list of questions with you to the orientation session.

Name: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Work Phone: _____

Occupation: _____

Primary Doctor: _____ Doctor Phone: _____

Cardiologist: _____ Cardiologist Phone: _____

Emergency contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

PERSONAL GOALS:

We want you to obtain personal goals while participating in Heart Track. Please list one or more goals below. We have given you a few examples. You may choose from the examples or fill in some of your own.

- Weight Management Feel Stronger (Increase Functional Capacity)/ Back To Normal Routine
 Quit Smoking Take Fewer Medications Learn More About Fighting Heart Disease

* Smoking history pack per day _____ # of years _____

Current: Packs per day _____ QUIT DATE: _____

Fill in your own goal: _____

RISK FACTORS FOR HEART DISEASE: Please Check All That Apply To You

- Sedentary (no routine exercise) Smoking Diabetes Obesity (overweight)
 High/Abnormal Cholesterol Hypertension (High blood Pressure)
 Stress (that effects your health) Family history of heart disease

SYMPTOMS:

Please give a brief description of your heart problem and the symptoms that caused you to seek medical attention.

CARDIAC RELATED PAIN:

Since your hospital discharge, have you had any chest pain, tightness, chest pressure, shortness of breath or any other angina like symptoms? (Any pain, discomfort you think is related to heart disease)

No Yes If yes, describe the pain and any treatment used to alleviate the pain:

If yes: Circle the Pain scale rating 0 = none 10 = worse ever experienced 0 1 2 3 4 5 6 7 8 9 10

More to complete on the back of this page



ARMC8962

PHYSICAL ACTIVITY LEVEL:

How would you rate your current level of physical activity (circle a choice) **Low** **Moderate** **High**

Do you exercise regularly? No Yes

Describe your exercise routine _____

Number of days per week _____ How many minutes each time _____

Do you have any medical problems that may limit your participation with the HeartTrack Program?

- arthritis joint problems hip or knee replacement back problems neck or spine problems
- fibromyalgia balance history of falls

Are you being treated by a physician for any chronic pain? No Yes

If yes, what is the treatment plan? _____

Location and Type of pain _____

Frequency of pain _____ Duration of pain _____

If yes: Circle the Pain scale rating 0 = none 10 = worse ever experienced 0 1 2 3 4 5 6 7 8 9 10

LEARNING BARRIERS:

Are there any important matters we need to know about to help provide an appropriate program for you? No Concerns

- Hearing Problems Problems with reading Problems with sight Concerns about exercise
- Trouble understanding the English language Problems learning new things

Other concerns: _____

Are you ready to begin learning about heart disease and start making the positive lifestyle changes?

No Yes If No explain why _____

Do you prefer to learn by: reading ____ video ____ group session ____ No preference ____

Thank you for completing this form. It will help us in developing your plan of care at HeartTrack.

Staff only section: Risk Stratification: Low Intermediate High

History	Date of onset/Detail	Cath report: Date	EF
Stable Angina	_____	_____	_____%
MI	_____	_____%	_____%
MI	_____	_____%	_____%
PCI/Stent	_____	_____%	_____%
PCI/Stent	_____	_____%	_____%
PCI/Stent	_____	_____%	_____%
CABG	_____ Details _____		

History: ____ HTN__ Hyperlipidemia ____ COPD ____ Renal Stenosis__ GERD
 ____ Diabetes ____ Cardiomyopathy ____ Thyroid Disease ____ Hysterectomy ____ Stroke
 ____ PAD ____ Arrhythmias ____ Heart Failure ____ Pacemaker ____ ICD ____ Post-op Atrial Fib
 other _____

LIPIDS: Date _____ Total _____ LDL _____ HDL _____ TRIG _____ HgbA1c Date: _____ result: _____
 Date _____ Total _____ LDL _____ HDL _____ TRIG _____ HgbA1c Date: _____ result: _____

Reviewed By: _____ Date: _____
 Time: _____ am/pm



ARMC8962



LifeStyle Center

HeartTrack Cardiac Rehabilitation

"Helping You Keep the Beat!"

Vocational Rehabilitation Screen

Vocational rehabilitation services are available for all participants that meet vocational rehabilitation criteria for assistance. The services provided may include assistance with: job change, job placement or financial support for cardiac rehabilitation program fees.

Name _____

Age _____

- I am retired
- I will not require assistance from Vocational Rehabilitation.
- I would like assistance from Vocational Rehabilitation

Remarks: _____

Staff Notes:

Office note sent to VR Date _____

Signature _____

Date _____

Time _____ am/pm



ARMC8964

HeartTrack Cardiac Rehabilitation

Rate Your Plate

For each question, mark the one answer that best matches your current eating habits.

Name: _____
Pretest

There are 4 pages to complete.

Topic	A	B	C
1. Grains 1 serving = 1 slice bread or tortilla; 1/2 bagel, roll, English muffin or pita; 1/2 cup cooked rice or paste; 1 cup cereal	<input type="checkbox"/> Usually eat: less than 4 servings of grain products a day	<input type="checkbox"/> Usually eat: 4-5 servings of grain product a day	<input type="checkbox"/> Usually eat: 6 or more servings of grain products a day
2. Whole grains Whole grain bread, brown rice, whole grain cereals like oatmeal, bran cereals, Cheerios, Wheaties, etc.	<input type="checkbox"/> Usually eat: White breads, white rice, low fiber cereals like corn flakes, Rice Krispies, etc.	<input type="checkbox"/> Usually eat: Less than 3 servings of whole grain products a day	<input type="checkbox"/> Usually eat: 3 or more servings of whole products a day
3. Fruits and vegetables 1 serving = 1/2 cup cooked or 1 med. fruit or 1 cup leafy raw vegetables or 4 oz. 100% fruit or vegetable juice	<input type="checkbox"/> Usually eat: 1 serving or less a day	<input type="checkbox"/> Usually eat: 2-4 servings a day	<input type="checkbox"/> Usually eat: 5 or more servings a day
4. Dairy foods 1 serving = 1 cup milk or yogurt; 1 1/2 - 2 oz. cheese	<input type="checkbox"/> Usually eat or drink: None OR less than 2 OR more than 4 servings a day	<input type="checkbox"/> Usually eat or drink: Average of 2 servings a day	<input type="checkbox"/> Usually eat or drink: 2-4 servings a day
5. Milk N/A _____	<input type="checkbox"/> Usually drink: Whole milk or cream	<input type="checkbox"/> Usually drink: 2% reduced-fat milk	<input type="checkbox"/> Usually drink: 1% or skim milk
6. Cheese Includes cheese on pizza, sandwiches, snacks, and in mixed dishes N/A _____	<input type="checkbox"/> Usually eat: Regular cheese such as cheddar, Swiss, and American	<input type="checkbox"/> Sometimes eat: Regular cheese such as cheddar, Swiss, and American	<input type="checkbox"/> Usually eat: Fat free or low fat cheese, part-skim cheese
7. Meat, chicken, turkey, or fish 1 serving = 3 oz. (the size of a deck of cards) or 1 regular hamburger, 1 chicken breast or leg, or 1 pork chop N/A _____	<input type="checkbox"/> Usually eat: More than 6 ounces of meat, chicken, turkey or fish a day	<input type="checkbox"/> Sometimes eat: More than 6 ounces of meat, chicken, turkey or fish a day	<input type="checkbox"/> Usually eat: 6 ounces or less of meat, chicken, turkey or fish a
8. Red meat Includes beef, hamburger, pork, lamb, or veal	<input type="checkbox"/> Usually eat: 3 times a WEEK or more	<input type="checkbox"/> Usually eat: 2 times a WEEK	<input type="checkbox"/> Usually eat: 1 time a WEEK or less or NONE
9. Red meat choices Includes beef, hamburger, pork, lamb, or veal	<input type="checkbox"/> Usually eat: High-fat cuts, such as ribs, brisket, T-bone steak, prime rib, sausage, regular or lean hamburger	<input type="checkbox"/> Sometimes eat: High-fat cuts, such as ribs, brisket, T-bone steak, prime rib, sausage, regular or lean hamburger	<input type="checkbox"/> Usually eat: Lean cuts such as round, loin, flank, lean pork and lamb such as loin and leg, veal, ground turkey breast, 93% lean hamburger, or NONE



HeartTrack Cardiac Rehabilitation

Rate Your Plate

For each question, mark the one answer that best matches your current eating habits.

10. Cold cuts, hot dogs, breakfast meats	<input type="checkbox"/> Usually eat: Salami, bologna, other cold cuts, hot dogs, bacon, sausage	<input type="checkbox"/> Sometimes eat: Salami, bologna, other cold cuts, hot dogs, bacon, sausage	<input type="checkbox"/> Usually eat: Lean roast beef, turkey breast, ham or low-fat cold cuts, low-fat hot dogs, low-fat bacon or sausage, or NONE
11. Chicken, turkey, etc. N/A _____	<input type="checkbox"/> Usually eat: Chicken, turkey, and other poultry WITH skin	<input type="checkbox"/> Sometimes eat: Chicken, turkey, and other poultry WITH skin	<input type="checkbox"/> Usually eat: Chicken, turkey, and other poultry WITHOUT skin
12. Fish	<input type="checkbox"/> Rarely or never eat: Any fish or seafood	<input type="checkbox"/> Usually eat: Fish 2-4 times a MONTH	<input type="checkbox"/> Usually eat: Fish 2 times a WEEK or more
13. Fried meats Do not eat meat _____	<input type="checkbox"/> Usually eat: Fried chicken and/or fried fish, and shellfish, cubed steak, pork chops, etc.	<input type="checkbox"/> Sometimes eat: Fried chicken and/or fried fish, and shellfish, cubed steak, pork chops, etc.	<input type="checkbox"/> Usually eat: Meats that are baked, broiled, grilled, poached, roasted, etc.
14. Meatless main dishes such as all-bean chili, bean burrito, lentil soup, meatless spaghetti sauce	<input type="checkbox"/> Rarely eat: or NEVER eat meatless main dishes	<input type="checkbox"/> Usually eat: Meatless main dishes less than twice a WEEK	<input type="checkbox"/> Usually eat: Meatless main dishes twice a WEEK or more
15. Fried foods Such as French fries, egg rolls, onion rings, etc.	<input type="checkbox"/> Usually eat: Fried foods twice a WEEK or more	<input type="checkbox"/> Usually eat: Fried foods 1-2 times a WEEK	<input type="checkbox"/> Rarely eat: or never eat fried foods
16. Fats and oils Added in cooking or at the table	<input type="checkbox"/> Usually add: Butter, stick margarine, or shortening	<input type="checkbox"/> Usually add: Soft margarine or veg. oils such as corn, sunflower, soy, etc.	<input type="checkbox"/> Usually add: Canola, olive, or peanut oils, light or fat free margarine, cooking spray, or NONE
17. Salad dressing and mayonnaise Added at the table	<input type="checkbox"/> Usually eat: Regular salad dressing or mayonnaise	<input type="checkbox"/> Sometimes eat: Regular salad dressing or mayonnaise	<input type="checkbox"/> Usually eat: Light or fat-free salad dressing or mayonnaise or NONE
18. Fats and oils 1 Serving = 1 teaspoon butter, margarine, shortening, oil, mayonnaise. 1 Tablespoon "light" margarine or salad dressing	<input type="checkbox"/> Usually eat: 3 servings per MEAL or more	<input type="checkbox"/> Usually eat: 2-3 per servings per MEAL	<input type="checkbox"/> Usually eat: 1 or less serving per MEAL or NONE
19. Salty snacks	<input type="checkbox"/> Usually eat: Salty snacks	<input type="checkbox"/> Sometimes eat: Salty snacks	<input type="checkbox"/> Rarely/Never eat: Salty snacks
20. Snacks	<input type="checkbox"/> Often eat: Regular chips, crackers, buttered popcorn, creamy dips or spreads	<input type="checkbox"/> Sometimes eat: Regular chips, crackers, buttered popcorn, creamy dips or spreads	<input type="checkbox"/> Usually eat: Low fat snacks such as fruit, pretzels, low-fat crackers, baked chips, low-fat popcorn



HeartTrack Cardiac Rehabilitation

Rate Your Plate

For each question, mark the one answer that best matches your current eating habits.

21. Desserts and sweets	<input type="checkbox"/> Often eat: Desserts and sweets	<input type="checkbox"/> Sometimes eat: Desserts and sweets	<input type="checkbox"/> Rarely/Never eat: Desserts and sweets
22. Desserts and sweets	<input type="checkbox"/> Usually eat: Doughnuts, cookies, cake, pie, pastry, or chocolate	<input type="checkbox"/> Sometimes eat: Doughnuts, cookies, cake, pie, pastry, or chocolate	<input type="checkbox"/> Usually eat: Fruit, angel food cake, low- fat or fat free sweets or NONE
23. Frozen desserts	<input type="checkbox"/> Usually eat: Regular ice cream, ice cream bars/sandwiches	<input type="checkbox"/> Sometimes eat: Regular ice cream, ice cream bars/sandwiches	<input type="checkbox"/> Usually eat: Sherbet, sorbet, low-fat frozen yogurt or ice cream or NONE
24. Nuts 1 serving = 2 Tablespoons nuts such as peanuts, pecans, almonds, walnuts, cashews, etc.	<input type="checkbox"/> Usually eat: NONE or more than 8 servings a WEEK	<input type="checkbox"/> Usually eat: 1-3 servings a WEEK	<input type="checkbox"/> Usually eat: 4-8 servings a WEEK
25. Beans Such as pintos, black beans, kidney beans, limas, peas, etc.	<input type="checkbox"/> Rarely/Never eat: Beans or peas	<input type="checkbox"/> Usually eat: Beans or peas an average of 1 times a WEEK	<input type="checkbox"/> Usually eat: Beans or peas 2-4 times a WEEK or more
26. Canned food, frozen packaged meals	<input type="checkbox"/> Usually eat: Regular canned foods or frozen or packaged meals	<input type="checkbox"/> Sometimes eat: Regular canned foods or frozen or packaged meals	<input type="checkbox"/> Usually eat: low fat/low sodium canned foods, frozen or packaged meals, plain frozen vegetables, or eat NONE
27. Added salt	<input type="checkbox"/> Usually add: Salt to food when cooking or at the table	<input type="checkbox"/> Sometimes add: Salt to food when cooking or at the table	<input type="checkbox"/> Rarely/Never add: Salt to food when cooking or at the table
28. Eating out	<input type="checkbox"/> Usually eat out: 3 times a WEEK or more	<input type="checkbox"/> Usually eat out: Average 2 times a WEEK	<input type="checkbox"/> Usually eat out: Less than 1 time a WEEK or eat low-fat restaurant meals
29. Beverages Soda, pop, fruit drink, fruit punch, kool-aid, lemonade, energy or sport drinks, tea, etc.	<input type="checkbox"/> Usually drink: 16 oz. or more of regular (non-diet) drinks per day	<input type="checkbox"/> Usually drink: 8-15 oz. of regular (non-diet) drinks per day	<input type="checkbox"/> Usually drink: Less than 8 oz. of regular (non-diet) drinks per day or NONE
30. Alcohol 1 drink = 12 oz. beer, 5 oz. wine, one shot (1 1/2 oz.) hard liquor or mixed drink with one shot	<input type="checkbox"/> Often drink: More than 1-2 drinks in a day	<input type="checkbox"/> Sometimes drink: More than 1-2 drinks in a day	<input type="checkbox"/> Rarely/Never drink: More than 1-2 drinks in a day; or drink NONE

Continue to page 4



HeartTrack Cardiac Rehabilitation

Rate Your Plate

For each question, mark the one answer that best matches your current eating habits.

Please complete the following:

Your goal weight: _____ When were you last at your goal weight? _____ Weight 1 year ago: _____

Please list any herbs, vitamins, or other over-the-counter health products you are taking:

Do you have any food allergies or intolerances? Please list. _____

Who plans and cooks your meals? Self _____ Spouse _____ other _____

On average, how many meals do you eat in a restaurant or eat take-out each week?

Breakfast _____ Lunch _____ Supper _____

What times do you usually eat your meals and snacks each day? (list a range if needed)

Breakfast _____ Lunch _____ Supper _____ Snacks _____

What are some things that make healthy eating difficult? (circle all that apply)

Emotional/stress eating large portions time/schedule cost "don't like healthy foods"

Frequent dining out fat salt sugar hunger/cravings "don't know what to eat"

Other: _____

Some favorite foods: _____

Are you exercising regularly? YES NO Type of exercise you do: _____

How many days per week do you exercise: _____ How long do you exercise at a time? _____

Reviewed by (staff): _____ Date: _____

Time: _____ am/pm



Cardiac Rehabilitation Questionnaire/PRE

Name _____

The purpose of this questionnaire is to determine your knowledge of heart disease before you start HeartTrack. During the program you will have the opportunity to attend weekly education sessions that will provide you with the answers to this questionnaire. You will get this questionnaire again at the end of this program. THIS IS NOT A QUIZ AND THERE IS NOT A GRADE ON THIS QUESTIONNAIRE.

Please circle the response you think is correct for each question.

T for TRUE F for FALSE N for NOT SURE

T F N 1. The coronary arteries are the main source of blood supply to the heart muscles.

T F N 2. Learning to take your pulse is an important part of your exercise program.

T F N 3. Irregular heartbeats can be a concern for someone with heart disease.

T F N 4. Heart disease patients may feel more depressed shortly after they go home than while they are in the hospital.

T F N 5. Walking for 30 minutes can be an excellent exercise in the prevention of heart disease.

T F N 6. Obesity is not a risk factor for heart disease.

T F N 7. The only signs of a heart attack are pain in the middle of the chest and down the left arm.

T F N 8. A heart attack means that part of the heart muscle has been without oxygen long enough to cause permanent heart muscle death.

T F N 9. Angina does permanent damage to your heart muscle.

T F N 10. After a heart attack, all sexual activity should be avoided for six months.

T F N 11. Difficulty having sexual intercourse may be caused by fears, stress, diabetes, or medications.

T F N 12. The buildup of cholesterol and other material in the arteries of the heart can cause a heart attack.

T F N 13. High blood sugar (Diabetes) can lead to changes in the blood vessels that can lead to heart disease.

T F N 14. Smoking will keep your HDL (Good Cholesterol) levels low.



- T F N 15. The best form of exercise for your heart is weight lifting.
- T F N 16. You can have high blood pressure without knowing it.
- T F N 17. A sudden weight gain of two to three pounds in a couple of days and/or a sudden increase in shortness of breath could be signs of heart failure.
- T F N 18. You can eat all the animal fat you want if you exercise on a regular basis.
- T F N 19. Smokers who quit after having a heart attack tend to live longer than those who keep smoking.
- T F N 20. Cigarette smoking can raise your heart rate and blood pressure.
- T F N 21. Your heart acts as a pump to circulate oxygen rich blood to your body.
- T F N 22. Stress will not increase your heartrate and raise your blood pressure.
- T F N 23. It is possible to improve your level of physical fitness by gradually increasing your physical activity.
- T F N 24. If you have chest pain, angina or heart attack symptoms that do not go away with rest and you need to use your nitroglycerin three times taken five minutes apart without total relief of your symptoms; you need to call 911 immediately.
- T F N 25. Not sleeping well, frequent headaches, overwhelming feelings, increased irritability, or loss of appetite can be signs of stress.
26. Which of the following has the most calories per gram?
- A. Sodium
 - B. Cholesterol
 - C. Starch
 - D. Fat
27. The recommended daily intake for Sodium is:
- A. 244 mg. (milligrams)
 - B. 400 mg.
 - C. 1500 mg.
 - D. 4000mg.
28. Which of theses items has the most monounsaturated fat.
- A. Roast Beef
 - B. Nuts
 - C. Hot Dogs
 - D. Cheese



Patient Financial Services

Patient's Name	Account #	Admit.	Balance

Alamance Regional Medical Center normally requires patients to pay their bills in full. However, we do offer two other options to help to get your bill paid.

Option A

You may make _____ monthly payments in the amount of _____. All payments are due every 28 days. Your account will not be set up in our system without a **reply from you**. Please call to confirm your wish to set up this monthly payment plan.

Option B

If you are unable to make the required monthly payment in option A, by completing the enclosed financial profile you may qualify to have your balance lowered.

Alamance Regional Medical Center requires **PROOF OF INCOME FOR THE HOUSEHOLD**, which includes

- * Copy of latest **FEDERAL TAX RETURN (Form 1040 A)**
- * Copy of the **RECENT PAY STUB** from current employer or unemployment benefit.
- * Copy of the **RECENT PAY STUB** from Social Security, Disability or Retirement (if applicable)
 - If you received the pay with a "Direct Deposit" directly to your Bank Account you must provide a copy of the current **BANK STATEMENT** showing the direct deposit.
- * Copy of proof of Alimony, Child Support, or any other source of income.

This information will be kept confidential. Please keep in mind we will not process incomplete applications. For further assistance please contact us. (**Please understand that due to confidentiality laws, we are only permitted to speak with the patient, legal guardian or power of attorney.)

Thank you





FINANCIAL PROFILE EVALUATION

Patient's name _____
Nombre del paciente _____
Guarantor's name _____
Nombre del Garante _____
Total # in Household _____
Total en su Familia _____

Admit. _____ Account # _____

DEPENDENTS		Social Sec. #	Date of Birth	Dependent's Relationship to	Employed?
First Name	Last Name	Nro. de Seguror Social	Fecha de Nacimiento	Relacion con el paciente	Trabaja ?
Nombre	Apellido				Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>

MONTHLY EXPENSES (Gastos Mensuales)

Cable TV (TV Cable)	\$ _____	Gas for you car (Gasolina)	\$ _____	Rent (Alquiler)	\$ _____
Car Ins. (Seguro del Auto)	\$ _____	Heat (Calefaccion)	\$ _____	Telephone (telefono)	\$ _____
Car Loan (Prestamo del Auto)	\$ _____	Home Ins. (Seduro da la casa)	\$ _____	Water (Agua Corriente)	\$ _____
Credit Card (Tarjeta de Credito)	\$ _____	Life Ins. (Seguro de vida)	\$ _____		\$ _____
Day care (Guarderia)	\$ _____	Lot Rent (Alquiler de Lote)	\$ _____		\$ _____
Electricity (Electricidad)	\$ _____	Medical Bills (Gastos Medicos)	\$ _____		\$ _____
Food (Alimentos)	\$ _____	Mortgage (Prest. de la casa)	\$ _____		\$ _____

INCOME (Ingresos)

* Do you work? Yes No Employer: _____
Usted Trabaja? Empleado

Salary: \$ _____ Per month Per week Per hour
Salario Par mes Por semana Por hora

* Does your spouse work? Employer: _____
Su esposa/o trabaja? Empleado

Salary: \$ _____ Per month Per week Per hour
Salario Par mes Por semana Por hora

* Unemployment Benefit(Beneficios de Desempleo)

Patient Yes No \$ _____ Spouse Yes No \$ _____
(Paciente) (Esposo/a)

* Social Security, Disability, or Retirement Income (Ingresos de Seguru Social, Incapacidad o Retiro)

Patient Yes No \$ _____ Spouse Yes No \$ _____
(Paciente) (Esposo/a)

* Alimony, Child Support, Others: \$ _____ Per month Per week Per hour
Mantencion Infantil, Otros. Par mes Por semana Por hora

* Do you own your home? Yes No Value of your Home / Other land \$ _____ / \$ _____
Usted es dueño de su Casa? Cual es el valor de su propiedad / terreno?

* Vehicle _____ Yes No Make (Marca): _____ Model (Modelo): _____ Year (Año): _____
Vehiculo

* 401k/Retirement \$ _____ Make (Marca): _____ Model (Modelo): _____ Year (Año): _____
401 k / Cuenta de retiro

* Stock and bonds \$ _____ * Savings \$ _____ * Life ins. cash value \$ _____
Acciones y Bonos Ahorros (Valor en efectivo de seguro da vida)

I cetrify that to the best of my knowledge all of the above Information Is true and correct.
Yo certifico de buena fe qua toda la informacion aqui mencionada es verdadera y correcta.



Signature of patient, legal guardian or Power of Attorney
Firma del paciente, guardian legal o apoderado.

Date
Fecha



Patient Financial Services

Account #

Patient's Name

Home Phone #

Garantor's Name

Address

Work Phone#

Check on the boxes below to select the option ARMC offers to get your bill paid.

I have chosen Option A
monthly payment plan in the amount of _____

If you have selected this option, please sign below and return this page or call our Patient Financial Services office at 336-538-8400 from 8:00am to 5:00pm Monday through Friday.

Signature of patient, legal guardian or Power of Attorney

Date

Time (am/pm)

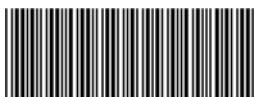
I have chosen Option B

If you have selected this option, please check below the documents you are sending and mail this page along with your financial profile.

- Copy of latest FEDERAL TAX RETURN (Form 1040 A).
- Copy of the RECENT PAY STUB from current employer.
- Copy of the RECENT PAY STUB from unemployment benefit. (if applicable)
- Copy of SPOUSE'S PROOF OF INCOME. (If applicable)
- Copy of the RECENT PAY STUB from, Social Security, Disability or Retirement (If applicable)
- Copy of the current BANK STATEMENT showing the direct deposit. (If applicable)
- Copy of proof of Alimony, Child Support, or any other source of income, (If applicable)
- NOTARIZED STATEMENT (If applicable)

AMOUNT YOU SUGGEST TO PAY TO ARMC MONTHLY: \$ _____

Thank you for your cooperation in this matter.



ARMC8894