



# TRI-CITY CARDIOLOGY

## Welcome Letter

Dear Patient,

Thank you for choosing Tri-City Cardiology for your care. Our goal is to provide you with very good care and service. The following information is provided to help you have a very good experience at our clinic:

- **New Patient Packet:** All new patients need to complete these forms and bring them to their visit:
  - Patient Information Form
  - Financial Policy
  - Authorization to release Personal Health Information (PHI)
  - Peripheral Vascular Disease (PVD) Screening
- **Items To Bring to Your Appointment:**
  - Current medication list including vitamins, supplements, and over the counter medications
  - Current insurance cards
  - Credit Card, Checkbook, or cash for payments owed at the time of service
- **Check-in Time:** It is **very important** that you check-in **20 minutes prior to your appointment time** to begin your registration process which includes updating your demographic, insurance and health information. Please allow enough time to park, if your appointment is at the Banner Heart Hospital Campus.
- **Late Arrival Policy:** If you arrive more than fifteen (15) minutes late, you may be asked to reschedule your appointment(s).
- **Testing Appointments:** It is very important to be on time for your testing appointment as these appointments run on time. If you are late, you may be asked to reschedule.
- **Cancellation Fee:** Failure to cancel any appointment within 24 hours (1 full business day, Mon-Fri) of your appointment will result in a **\$50.00** charge added to your account.
- **Co-Pay, Co-Insurance, and Account Balance Payments:** Please be prepared to pay your co-payments, deductibles, and any outstanding balances due at the time of your visit. Please refer to the Financial Policy for your financial obligations as a patient.
- **Patient Rooming:** The rooming process begins when the medical assistant escorts you from the waiting rooms to an exam room to obtain updated health information, vital signs, etc to prepare for your visit with the physician.
- **Appointment Time:** Your appointment time is the time you are to begin your exam with the provider or test/procedure. Your physician will be using a computer in the exam room to access and update your medical information as part of an electronic medical record process.

- **Checkout Process:** The Discharge Scheduler will schedule any testing or follow up visits ordered by the physician. You will be provided a Clinical Summary of your visit at that time.
- **Communicating with our Practice:** Following your visit, there are several methods to reach our staff:
  - **Patient Portal** – <https://bit.ly/3lURmn9> or <https://www.medfusion.net/tri-citycardiologyconsultantspc-25364/portal/#/user/login>  
 This is a secure website for patients to communicate with our practice, request appointments and medical records, receive statements and pay account balances, etc. You will receive an email with a specific link to register for the new patient portal. After initial registration, you may return to the Medfusion website by using the on our website or saving the link as a favorite on your browser.
    - **This is our preferred method of communications with patients.**
  - **Telephone** – our phone lines are open from 8 am to 4 pm Monday through Friday with live agents to direct your call to the appropriate member of our staff for timely patient care.
  - **Website:** [www.TriCityCardiology.com](http://www.TriCityCardiology.com)  
 Visit our website to see information about our physicians and our practice but link to the **Patient Portal** for **SECURE** communication with our practice.
- **Patient Satisfaction:** Your satisfaction is very important to us. You will be receiving a confidential, electronic survey via e-mail from Press Ganey after your visit. Please provide your honest feedback so we can continue to improve our services.

Thank you for choosing Tri-City Cardiology for your medical care!

#### **The physicians and staff at Tri-City Cardiology**

**Tri-City Cardiology**

**Phone: 480-835-6100**

**Fax: 480-461-4243**

[www.TriCityCardiology.com](http://www.TriCityCardiology.com)

**Patient Portal:** <https://bit.ly/3lURmn9> or  
<https://www.medfusion.net/tri-citycardiologyconsultantspc-25364/portal/#/user/login>

**PATIENT INFORMATION FORM**  
**Tri-City Cardiology**

Patient Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_  
First Last M.I.

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Reason for Visit (current symptoms today): \_\_\_\_\_

Recent hospitalization? If yes, please explain: \_\_\_\_\_

Local Pharmacy Name (crossroads): \_\_\_\_\_ City: \_\_\_\_\_ Ph: \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

**Advanced Directives:** ☐ None ☐ POA ☐ Living Will ☐ Healthcare Proxy

**Do You Use Tobacco:** ☐ Current ☐ Former ☐ Never **If former, Age Quit:** \_\_\_\_\_

**If Yes, Type:** ☐ Chewing ☐ Cigarettes ☐ Pipe ☐ Smokeless  
Packs/day \_\_\_\_\_ Years used \_\_\_\_\_ Passive smoke exposure: ☐ No ☐ Yes

Are you interested in tobacco cessation information? ☐ Yes ☐ No

**Have you ever been diagnosed or are taking medications for the following conditions:**

**Diabetes:** ☐ Yes ☐ No ☐ Unknown **If Yes, Type:** ☐ Type 1 (Juvenile) ☐ Type 2 (Adult onset) **Year diagnosed** \_\_\_\_\_

**High Cholesterol:** ☐ Yes ☐ No ☐ Unknown

**If Yes, Type:** ☐ Cholesterol ☐ Triglycerides ☐ Cholesterol + Triglycerides ☐ Low HDL Syndrome

**High Blood Pressure:** ☐ Yes ☐ No ☐ Unknown **Year diagnosed** \_\_\_\_\_

**Family History of Heart Disease (CAD) prior to age 55:** ☐ Yes ☐ No ☐ Unknown ☐ Adopted (Unknown)

**Peripheral Vascular Disease (poor circulation in legs):** ☐ Yes ☐ No ☐ Unknown

**Are you allergic to any medications:** ☐ Yes ☐ No

**Medications you are allergic to:** \_\_\_\_\_

**Reaction:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Other allergies (food, adhesive tape, iodine, latex, etc.):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications** - please list all prescription, non-prescription, vitamins and nutritional supplements; list additional meds on back of paper if needed

CURRENT MEDICATIONS	DOSE (Strength)	DOSAGE (How many & times per day)	DO YOU NEED ANY REFILLS?
<i>Example: Lopressor</i>	<i>50 mg</i>	<i>1 tablet, two times a day</i>	30 Days or 90 Days
			<input type="checkbox"/> Yes <input type="checkbox"/> 30 <input type="checkbox"/> 90
			<input type="checkbox"/> Yes <input type="checkbox"/> 30 <input type="checkbox"/> 90
			<input type="checkbox"/> Yes <input type="checkbox"/> 30 <input type="checkbox"/> 90
			<input type="checkbox"/> Yes <input type="checkbox"/> 30 <input type="checkbox"/> 90
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			<input type="checkbox"/> Yes <input type="checkbox"/> 30 <input type="checkbox"/> 90
			<input type="checkbox"/> Yes <input type="checkbox"/> 30 <input type="checkbox"/> 90
			<input type="checkbox"/> Yes <input type="checkbox"/> 30 <input type="checkbox"/> 90

**Review of Symptoms:** Check only the problems you are currently experiencing

	Y	N		Y	N		Y	N	
<b>Cardiac:</b>	<input type="radio"/>	<input type="radio"/>	Chest Pain (pressure)	<input type="radio"/>	<input type="radio"/>	Diaphoresis (excessive perspiration)	<input type="radio"/>	<input type="radio"/>	Orthopnea (trouble breathing lying down)
<b>Cardiac:</b>	<input type="radio"/>	<input type="radio"/>	Palpitation (fluttering)	<input type="radio"/>	<input type="radio"/>	Syncope (loss of consciousness)	<input type="radio"/>	<input type="radio"/>	PND (trouble breathing at night)
<b>Vascular:</b>	<input type="radio"/>	<input type="radio"/>	Claudication (leg pain)	<input type="radio"/>	<input type="radio"/>	Edema (swelling)			
<b>Constitutional:</b>	<input type="radio"/>	<input type="radio"/>	Weight Gain	<input type="radio"/>	<input type="radio"/>	Weight Loss	<input type="radio"/>	<input type="radio"/>	Fever
<b>HEENT:</b>	<input type="radio"/>	<input type="radio"/>	Visual Changes	<input type="radio"/>	<input type="radio"/>	Hearing Loss			
<b>Respiratory:</b>	<input type="radio"/>	<input type="radio"/>	Snoring	<input type="radio"/>	<input type="radio"/>	Hemoptysis (coughing up blood)	<input type="radio"/>	<input type="radio"/>	Dyspnea (shortness of breath)
<b>Gastrointestinal:</b>	<input type="radio"/>	<input type="radio"/>	Nausea	<input type="radio"/>	<input type="radio"/>	Reflux	<input type="radio"/>	<input type="radio"/>	Bleeding
<b>Genitourinary:</b>	<input type="radio"/>	<input type="radio"/>	Hematuria (blood in urine)	<input type="radio"/>	<input type="radio"/>	Nocturia (nighttime urination)			
<b>Neurology:</b>	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Memory Loss	<input type="radio"/>	<input type="radio"/>	Seizures
<b>Psychiatric:</b>	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Hallucinations			
<b>Hematologic:</b>	<input type="radio"/>	<input type="radio"/>	Acute Anemia	<input type="radio"/>	<input type="radio"/>	Thrombocytopenia (low platelet count)			
<b>Endocrine:</b>	<input type="radio"/>	<input type="radio"/>	Goiter (enlarged thyroid)	<input type="radio"/>	<input type="radio"/>	Tremors			
<b>Derm (Skin):</b>	<input type="radio"/>	<input type="radio"/>	Rash	<input type="radio"/>	<input type="radio"/>	Skin Sores			
<b>Musculoskeletal:</b>	<input type="radio"/>	<input type="radio"/>	Joint Pain	<input type="radio"/>	<input type="radio"/>	Myalgia (muscle pain)			

**Past Medical History** – Place a check mark in the box for any conditions that apply:**Respiratory:** ☐ COPD ☐ Pulmonary Embolus ☐ Pulmonary Hypertension ☐ Sleep Apnea ☐ Other:\_\_\_\_\_**Renal:** ☐ End Stage Renal Disease ☐ Renal Artery Stenosis ☐ Renal Insufficiency ☐ Other:\_\_\_\_\_**Endocrine:** ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Obesity ☐ Other:\_\_\_\_\_**Oncology:** ☐ Breast Cancer ☐ Skin Cancer ☐ Lung Cancer ☐ Prostate Cancer ☐ Other:\_\_\_\_\_☐ Chemotherapy ☐ Radiation ☐ Other:\_\_\_\_\_**Cardiac:** ☐ Arrhythmias ☐ Congestive Heart Failure ☐ CAD ☐ Heart Attack (MI) ☐ Valvular Heart Disease☐ CABG (Bypass) ☐ Coronary Stent ☐ ICD ☐ Pacemaker ☐ PTCA (Angioplasty) ☐ Other:\_\_\_\_\_**Vascular:** ☐ Abdominal Aneurysm ☐ Peripheral Arterial Disease ☐ Carotid Disease ☐ DVT ☐ Thoracic Aneurysm☐ Varicose Veins ☐ Amputation ☐ Aneurysm Repair ☐ Vein Stripping ☐ Other:\_\_\_\_\_**List any other medical conditions:** \_\_\_\_\_**List any other surgeries:** \_\_\_\_\_**Family History** – Checkmark any conditions that apply ☐ No Relevant Family History ☐ Unknown - Adopted

	Current Age	Age at Death	Heart Attack	Arrhythmia	Heart Failure	Aneurysm	Stroke	High Blood Pressure	High Cholesterol	Diabetes	Lung Disease	Renal Disease	Cancer
<b>Mother</b>													
<b>Father</b>													
<b>Other</b>													

Other pertinent family history:\_\_\_\_\_

**Do you consume Alcohol:** ☐ Yes ☐ No ☐ Former **If Yes, What Type:** ☐ Beer ☐ Wine ☐ Liquor ☐ Variety**If Yes, Frequency:** ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially **Amount:**\_\_\_\_\_**Do you consume Caffeine on a daily basis:** ☐ Yes ☐ No **Cups per day:**\_\_\_\_\_**If Yes, What type:** ☐ Chocolate ☐ Coffee ☐ Energy Drink ☐ Soda ☐ Tablets ☐ Tea ☐ Other:\_\_\_\_\_**Do you follow a specific diet: (check all that apply)**☐ Diabetic ☐ Low Carb ☐ Low Fat, Low Cholesterol ☐ Low Salt ☐ No Added Salt ☐ No Specific Diet☐ Regular ☐ Renal ☐ Vegetarian ☐ Weight Loss ☐ Other :\_\_\_\_\_**Drug use/abuse:** ☐ Yes ☐ No ☐ Former **If Yes, what type:** \_\_\_\_\_



# TRI-CITY CARDIOLOGY

## **Financial Policy**

Dear Patient,

Our goal is to provide you with very good care and service. Attached is a copy of our financial policy. It is very important you review this policy. If you have any questions before your appointment please call (480) 844-0401 to speak with a financial counselor.

Each visit, during the registration process, your statement or account balance will be reviewed with you by a financial counselor or registrar prior to services rendered. The final part of your registration process will be to review your financial obligations to ensure the accuracy of your bill. We will ask you to pay any co-payments, deductibles, and outstanding balances at this time.

In addition, your registration process will include updating your demographic, insurance, and health information. This process will improve the quality of patient information we use to care for you.

Being true to our Mission Statement we will work collaboratively with patients who are under financial hardship to develop fair and reasonable payment plans. Financial hardship is determined by policy and is a formal process that must be a joint effort between a financial counselor and the patient. A patient, who has the ability to pay and has not been formally determined to be in financial hardship, is expected to pay at the time of service and maintain no outstanding balance.

Our policy states that any account balance remaining after insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time. All co-pays, deductibles, and previous account balances must be paid before additional services will be rendered.

We hope this brief overview is helpful. We are excited about the opportunity to provide you with very good care and service. If you have any questions or concerns, please contact Billing at 480-844-0401. Thank you.

### **Billing Questions**

6343 E. Main Street, Suite 12  
Mesa, AZ 85205  
(480) 844-0401

## TRI-CITY CARDIOLOGY FINANCIAL POLICY Patient Responsibilities

We will bill your insurance company. Please have all current insurance cards available so that we may copy the front and back of the card for accurate information. It is your responsibility to inform Tri-City Cardiology (TCC) of any insurance changes. If accurate insurance information is not provided for timely submission of a claim, you will be held responsible for the full amount of the charges.

You will be asked to sign an authorization for your insurance carrier to send payments **directly** to TCC. Any payments sent directly to the patient should be forwarded to TCC with the Explanation of Benefits to prevent your account being subject to collection procedure and legal action. Authorization must be signed at the initial visit, upon any change in insurance and annually thereafter.

Resources are available through your insurance company to understand your insurance coverage. These services will help you to verify that TCC is a participating provider with your insurance company. All referrals to TCC are to be obtained **prior** to your appointment. This will prevent your appointment from needing to be rescheduled.

### Payment Policy

#### Insured

All co-pays and deductibles must be paid before services are rendered. If unable to pay your copay at the time of service, your appointment may be rescheduled. Non-contracted insurance claims will be submitted to the insurance company as a courtesy to you however the charges remain your responsibility. If no response is received from your insurance within 60 days, payment must be made by you.

#### Non-Insured

TCC requires full payment at the time of service unless prior arrangements have been made with our Billing Office.

#### Balances Due

Patient balances remaining after insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time.

#### Medical Forms

TCC requires full payment of \$50.00 at the time your Insurance forms (FMLA, FAA Clearance, Disability, etc.) are dropped off for completion. Completion of forms is not paid by your insurance company.

#### 24 hour Cancellation for Appointments

TCC requires a 24 hour advance notice for all appointment cancellations. 24 hour advanced notice is defined as 1 full business day, Monday through Friday. Failure to cancel your appointment within these hours will result in a \$50.00 charge added to your account. This charge is not covered by your insurance and is the patient's responsibility.

Hospitalizations It is your responsibility to notify your insurance company and primary care physician's office in the event of an unscheduled hospitalization. It is also your responsibility, not the hospital's to provide TCC with your insurance information.

#### Non-Sufficient Funds/Return Checks

TCC will pass along to the patient a \$40.00 NSF bank charge for all returned checks. This fee will be added to your account and is the patient's responsibility. The financial institution may charge additional fees to you directly.

---

Print Name

Date of Birth

---

Signature

Today's Date

**AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION**  
**Tri-City Cardiology**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**1) Please check (✓) one only:**

☐ I only want my medical information released to myself.

☐ I give Tri-City Cardiology Consultants, P.C. and staff authority to release medical information regarding my care to the following individuals:

**Individuals Name**

**Relationship to Patient**


**2) Emergency Contact Name** \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

**3) Please Initial below:**

\_\_\_\_\_ Yes, I give my permission to leave messages regarding my test results, appointments, etc., at the following phone numbers \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_ No, do not leave messages regarding my test results, appointments, etc.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

**NOTE: The above authorization remains effective until patient notifies practice in writing of any change.**

\*\*\*\*\*

**FOR OFFICIAL USE ONLY**

We attempted to obtain written acknowledgment of receipt of this **AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION** but could not because:

☐ Individual refused to sign ☐ Communication barrier ☐ Care provided was emergent ☐ Other: \_\_\_\_\_

Employee Name \_\_\_\_\_ Date \_\_\_\_\_



# PERIPHERAL VASCULAR DISEASE (PVD) SCREENING

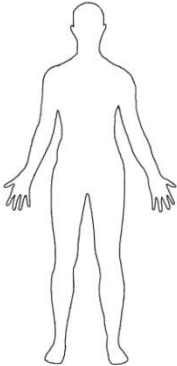
## Tri-City Cardiology

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Peripheral Vascular Disease (PVD) is a common circulatory problem in which vessels carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PVD.

**Please circle “Yes” or “No” on the following questions and check all boxes that apply:**

<p>1. Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? <span style="float: right;">Yes    No</span></p>	<p>6. If you have pain, does the pain subside with rest? <span style="float: right;">Yes    No</span></p>
<p>2. Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, belly, legs, or arms? <span style="float: right;">Yes    No</span> If yes, dates: _____</p>	<p>7. Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? <span style="float: right;">Yes    No</span></p>
<p>3. When you walk, do you experience aching, Cramping, or pain in your arms, legs, thighs, or buttocks? <span style="float: right;">Yes    No</span></p>	<p>8. Do you have any painful sores or ulcers on legs or feet that do not heal? <span style="float: right;">Yes    No</span></p>
<p>4. If you answered Yes to #3, when do you feel the pain:</p> <div style="margin-left: 20px;"> <input type="checkbox"/> After walking 1 block  <input type="checkbox"/> Climbing a flight of stairs  <input type="checkbox"/> After walking 100 yards  <input type="checkbox"/> Walking at increased speed         </div>	<p>9. Are your legs or arms pale, discolored, or bluish? <span style="float: right;">Yes    No</span></p>
<p>5. If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.</p> <div style="text-align: center; margin-top: 20px;">  </div>	<p>10. Check all that apply:</p> <div style="margin-left: 20px;"> <input type="checkbox"/> I am a current smoker  <input type="checkbox"/> I have a history of smoking  <input type="checkbox"/> I have diabetes  <input type="checkbox"/> I have a family history of diabetes  <input type="checkbox"/> I have high cholesterol  <input type="checkbox"/> I have a family history of high cholesterol  <input type="checkbox"/> I have high blood pressure/hypertension  <input type="checkbox"/> I have a family history of high blood pressure/hypertension  <input type="checkbox"/> I have coronary artery disease (CAD)  <input type="checkbox"/> I have a family history of coronary artery disease  <input type="checkbox"/> I have had a stroke/mini-stroke/TIA  <input type="checkbox"/> I have a family history of stroke/mini-stroke/TIA         </div>



# TRI-CITY CARDIOLOGY

## MEDICATION MANAGEMENT

Dear Patient,

Proper management of your medications is very important to your care plan. It is important that we work together to educate you on your medications and that we maintain an accurate medication list.

- **Please bring your current medication lists, including dosage and instructions to every office visit with your physician.**
  - Be prepared to provide information about **new** medications since your last office visit.
- **If you have been discharged from the hospital in the last sixty (60) days, it is important to bring your hospital discharge instructions that contain your most recent medication instructions.**

### **Managing Prescriptions Refills**

Tri-City Cardiology is compliant with Electronic Prescription requirements, therefore:

- **All refill requests for medication must be made through your local or mail order pharmacy.**
- If you need a refill authorization (if you are out of refills), you must call your pharmacy. The pharmacist is in the best position to safely and accurately coordinate the request with our staff.
- Request your refills at least 7 days BEFORE you will run out of medication to allow time for processing of your refill.
- If your prescription has expired, allow at least two weeks for your pharmacy to process the new prescription.
- If your prescription medication requires authorization from your insurance or you use a mail order pharmacy, allow at least 30 days for this process to be completed.

### **Understanding Your Medications**

It is important that you know what medication(s) you are taking and how to take them. Be prepared for your visit by asking questions about your medications of your other physician(s) who prescribe them or pharmacist.

- Know the name and dosage of the medication(s). Keep a list with you.
- Know when you should take your medications and what to do if you miss a dose.
- Know the side effects (for example, drowsiness or nausea).
- Know if your medication(s) could interact with any over the counter non-prescription medications that you may be taking or whether you should avoid alcohol while taking a medication.

Thank you for your cooperation with following the above instructions to help process all of your medication requests and questions timely and accurately. Our goal is to ensure you understand and take your medications as directed by your physician for your best health benefit.

**Tri-City Cardiology**  
**Phone: 480-835-6100    Fax: 480-461-4243**  
**Patient Portal: <https://bit.ly/3IURmn9>**



# TRI-CITY CARDIOLOGY

## Patient Code of Conduct

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Tri-City Cardiology expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

### **The following behaviors are prohibited:**

- Possession of firearms or any weapon
- Physical assault, arson or inflicting bodily harm
- Making verbal threats to harm another individual or destroy property
- Intentionally damaging equipment or property
- Making menacing gestures
- Attempting to intimidate or harass other individuals
- Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality

In order to ensure that the privacy of our patients and staff is protected and so as to ensure that the physician-patient relationship remains confidential and private, Tri-City Cardiology does not permit anyone to record, video tape or photograph our facilities in any way during any visit or appointment with us.

**If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.**

**Our practice follows a zero-tolerance policy for aggressive behavior directed by patients/visitors against our staff.**

\*Adults are expected to supervise children in their care.



# TRI-CITY CARDIOLOGY

## Directions and Maps

### Fiesta Office

**1580 N. Fiesta Blvd Ste. 100 Gilbert, AZ 85233**

**Main Phone: (480) 835-6100**

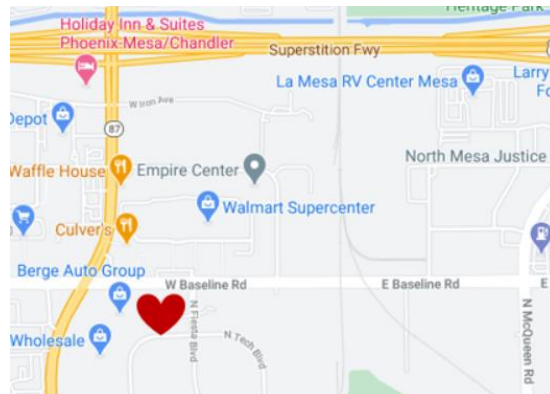
- Traveling **East** on Highway 60 in Mesa, take the Country Club Drive exit Turn South (Right) onto Country Club Drive and then turn left on Baseline Rd.
- Turn Right on Fiesta Blvd
- Tri-City Cardiology is on the Southwest corner of Baseline and Fiesta Blvd. in Suite 100

**-OR-**

- Traveling **West** on Highway 60 in Mesa, take the Mesa Drive/McQueen exit
- Turn South (Left) onto Mesa Drive/McQueen and then turn Right on Baseline Rd.
- Turn Left on Fiesta Blvd
- Tri-City Cardiology is on the Southwest corner of Baseline and Fiesta Blvd. in Suite 100

**-OR-**

- Traveling **North or South** on highway 101, take the Southern Ave/Baseline Rd exit
- Turn East on Baseline Rd and then turn Right on Fiesta Blvd
- Tri-City Cardiology is on the Southwest corner of Baseline and Fiesta Blvd. in Suite 100

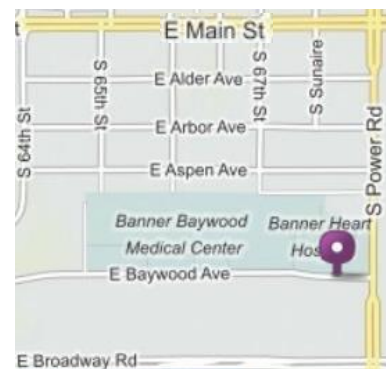


### Baywood Offices – Banner Heart Hospital Campus

**6750 E. Baywood Ave. • Suite 301 • Mesa, AZ 85206**

**Arrhythmia Center: Suite 506 Main Phone: (480) 835-6100**

- Traveling **East** or **West** on Highway 60 in East Mesa, take the Power Road exit
- Turn North onto the Power Road exit
- Travel through the stop lights at Southern Ave., Broadway Rd and Baywood Ave. Immediately after Baywood Ave., take the entrance into the Banner Heart Hospital
- Travel up the ramp to the top level of the Banner Heart parking deck. Park and enter the hospital on the lobby level. There are two sets of elevators off the main lobby. Take either set of elevators to the 3<sup>rd</sup> floor
- We are located in suite 301



Note: A complementary shuttle service will be driving around the parking lot throughout the day to assist you to and from the front entrance of the Heart Hospital to your vehicle.

### **Val Vista Office – Copper Point Business Park**

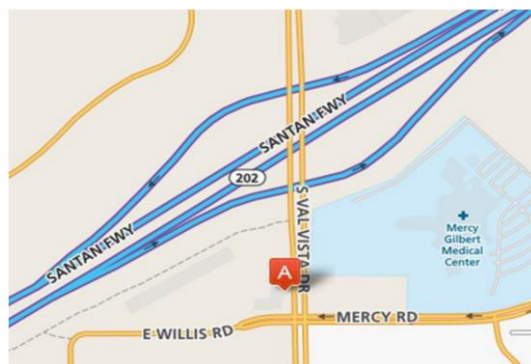
**3530 S. Val Vista Dr. • Suite 103 • Gilbert, AZ 85297**

**Main Phone:** (480) 835-6100

- Traveling **East** or **West** on Highway 60 in East Mesa, take the S. Val Vista exit, then head south

**-OR-**

- Traveling **East** or **West** on South Santan Fwy/Loop 202, take the S. Val Vista exit, then head South
- Turn right (west) on Willis Road
- Make your first right into parking lot
- We are located in suite 103



### **San Tan Valley Office – Pinal Professional Village**

**36543 N. Gantzel Rd. • Bldg 15, Suite 101 • San Tan Valley, AZ 85140**

**Main Phone:** (480) 835-6100

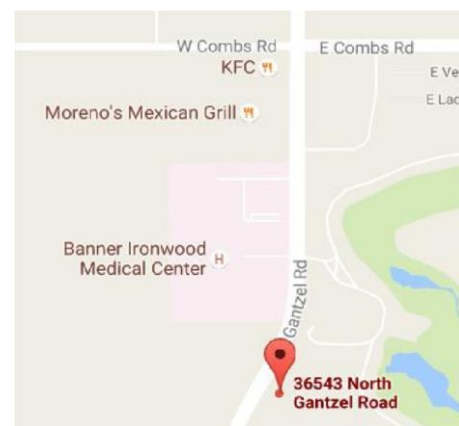
- Traveling **East** or **West** on Highway 60 in East Mesa, Take the Ironwood exit, # 195
- Turn South onto S. Ironwood Drive
- S. Ironwood Dr. turns into N. Gantzel Road
- Continue south through Combs, to the 2<sup>nd</sup> stop light (no street name)
- Turn left into the complex and make a sharp left and follow the front of the buildings to our office location

**-OR-**

- Traveling **East** on Hunt Highway, take a left on Bella Vista Road
- Turn left on Gantzel Road
- Go through 2 stop light and turn into complex

**-OR-**

- Traveling **West** on Hunt Highway, take a right on Bella Vista Road
- Turn left on Gantzel Road
- Go through 2<sup>nd</sup> stop light and turn into complex



### **Superstition: Cardiology Services, Vein Center**

**6402 E. Superstition Springs Blvd. Suite 114 • Mesa, AZ 85206**

**Main Phone:** (480) 835-6100

- Traveling **West** on Highway 60 in East Mesa, take Power Rd. exit
- Turn left onto Power Rd.
- Turn right on Superstition Springs Blvd.
- Follow the curve to the right and take your first right at Test Drive
- Take the first left into the parking lot

**-OR-**

- Traveling **East** on Highway 60 in East Mesa, take the Superstition Springs Blvd. exit
- Turn right onto Superstition Springs Blvd
- Follow to the stop light at Test Drive and turn left
- Take the first left into the parking lot

