

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Last Name: _____	First Name: _____	Mid. Initial: _____
DOB: _____	SSN#: _____	Sex: _____
Race: _____	Ethnicity: _____	Language: _____
Home Address1: _____	Apt/Suite #: _____	
City, State, Zip: _____	Email: _____	
Home Phone: _____	Work Phone: _____	Mobile Phone: _____
Preferred Phone Method: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile    Communicate by: <input type="checkbox"/> Voice <input type="checkbox"/> Email <input type="checkbox"/> Text		

**EMPLOYER INFORMATION- Employment Status: «EmploymentStatus»**

Name: _____	Phone#: _____
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**EMERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)**

Name: _____	Phone _____	Relationship: _____
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**Name of Primary Care Provider:** \_\_\_\_\_

**PLEASE GIVE THE RECEPTIONIST YOUR CURRENT INSURANCE CARD AND YOUR DRIVERS LICENSE  
PRIMARY INSURANCE**

Plan/Policy Name: _____	Group #: _____
Plan Phone: _____	Subscriber DOB: _____
Subscriber Name: _____	Subscriber ID: _____

**SECONDARY INSURANCE**

Plan/Policy Name: _____	Group #: _____
Plan Phone: _____	Subscriber DOB: _____
Subscriber Name: _____	Subscriber ID: _____

**PREFERRED PHARMACY**

Pharmacy Name: _____	Pharmacy Phone: _____
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**PATIENT METHOD OF DISCLOSURES**

*The HIPAA Privacy Rule gives the individual the right to request their confidential communications be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.*

<b>Home Phone:</b> _____ <input type="checkbox"/> Ok to leave detailed message <input type="checkbox"/> Leave message with call back number only  <input type="checkbox"/> <b>Ok to mail to my home address listed above</b> <input type="checkbox"/> <b>I have a Power of Attorney (POA)</b>	<b>Work Phone:</b> _____ <input type="checkbox"/> Ok to leave detailed message <input type="checkbox"/> Leave message with call back number only  <input type="checkbox"/> <b>Ok to E-mail to «PatientEmail»</b> <b>Name:</b> _____	<b>Mobile Phone:</b> _____ <input type="checkbox"/> Ok to leave detailed message <input type="checkbox"/> Leave message with call back number only  <input type="checkbox"/> <b>Ok to sign up for patient portal</b> <input type="checkbox"/> <b>I have an Advance Directive (Living Will)</b>
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**List any Persons Allowed to obtain your Health Info on your behalf:** \_\_\_\_\_

I am aware that Florida Cardiology uses a third-party call center to confirm appointments. I am aware that by providing my home and mobile phone number and email, I am agreeing to receive automated phone calls, text messages and email reminders. I am aware if at any time I no longer want these services, it is my responsibility to notify the office in writing or reply to third-party Company to opt out.

**Patient or authorized person's signature:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Authorization for Treatment**

**Consent to treatment:** I and/or authorized representative voluntarily consent to any and all medical care by Florida Cardiology that may include but not limited to examinations, tests, photographs, and treatments by physicians and the staff. No promises have been made to me as to the results of treatments or examinations.

**Patient or authorized person's signature:** \_\_\_\_\_

### **Authorization for Release of Information**

**Authorization for Release of Confidential Information:** I hereby authorize Florida Cardiology to release medical information contained in my (the patient's) records to any insurance carrier, employer or other third party intermediary utilized by the patient for the purpose of obtaining information and/or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of records may also be sent to referring physicians and primary care providers for continuity of care. Medical records released may include any diagnostic or therapeutic information of visits and/or procedures performed in our office.

**Patient or authorized person's signature:** \_\_\_\_\_

### **Consent for Review of Prescription History**

I authorize Florida Cardiology to access my prescription history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medications used in the past. I understand my prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff.

**Patient or authorized person's signature:** \_\_\_\_\_

### **Notice of Privacy Practice Acknowledgement Form**

I understand that I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been offered a copy of Florida Cardiology's Notice of Privacy Practices (available in our office or on our website) and understand that the Notice may change at any time. I give consent to Florida Cardiology to obtain my prior medical records from outside practices and send office notes to other physicians to coordinate care on my behalf. You have the right to revoke this consent, in writing, except if we have already made releases in reliance on your prior consent.

**Patient or authorized person's signature:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Financial Policy

In compliance with the Federal Consumer Protections Act, Florida Cardiology is providing you with information regarding your financial responsibilities.

We ask that you take the time to read our policy so we can avoid any misunderstandings. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions.

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care.

**Insurance:** Florida Cardiology participates in many insurance plans. Please contact your insurance company to make sure we participate with your insurance. We do our best in verifying your eligibility and benefits, however, it is your responsibility to know your insurance coverage. It is our policy that you provide us with your insurance card at every visit to our office. If you cannot provide active insurance coverage at the time of services rendered you will be considered uninsured and payment will be due at time of service. It is your responsibility to notify Florida Cardiology of any insurance and/or policy changes.

**Referral / Authorization:** If your insurance company requires a referral/authorization for office visits, testing, or procedures, you are responsible for obtaining the referral/authorization. If the referral/authorization is not obtained, you will be responsible for payment in full for services rendered on the date of service. Some insurance plans require your primary care provider to pre- authorize services done by a specialist. As a courtesy, Florida Cardiology will try to obtain the referral/authorization for you.

**Patient Payments:** Co-pays, deductibles, co-insurance (20%, etc.), services not covered by your insurance plan or outstanding balances are due at the time of your appointment. We accept cash, checks, and most major credit cards. Returned checks will be subject to a fee of \$25.00 charged by this office for each check returned to us by your bank. Should you have any balances on your account, we will provide you with a monthly statement. The statement will include but not limited to amounts billed to you, any payments received and detailed aging. It is your responsibility to keep your mailing address current. In cases of hardship, please contact manager or billing representative to see if payment arrangements can be made for outstanding balances. This will be done on case by case bases.

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Collections Policy:** Payment for services which have been billed to you is due in full within 30 days of receipt of your billing statement. If you fail to pay within a reasonable amount of time or cooperate with the terms of an agreed upon payment schedule, your account may be turned over to an outside agency for resolution.

**No Show Fee:** Effective June 16, 2006 there will be a \$25.00 fee assessed for no show appointments. No shows are appointments that are not cancelled with a 24 hour notice. With appropriate notice, we are able to schedule other patients in a vacant time slot and to also decrease wait times by not having to work-in emergent patients. Some of our testing and procedures have a separate no show policy.

I assign payment directly to Florida Cardiology, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment. I will assist in the collection of my insurance should there be a delay in payment. I agree to actively pursue collection insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.

I understand that I am financially responsible for my (the patient's) account with Florida Cardiology, regardless of my insurance benefits.

I authorize a copy of this form to be valid as the original.

**Patient or authorized person's signature:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Initial History and Physical**

Please list Primary Care Provider and other healthcare providers involved in your care: \_\_\_\_\_

**Reason for visit:**

\_\_\_\_\_

<b>Medical History-</b> Please list past medical diagnosis (illnesses & Conditions)			
<b>Diagnosis</b>	<b>Date</b>	<b>Diagnosis</b>	<b>Date</b>

<b>Previous Surgery-</b> Please list any surgeries			
<b>Surgery</b>	<b>Date</b>	<b>Surgery</b>	<b>Date</b>

**Do you have an implantable cardiac device?**  YES  NO

Implantable Defibrillator (ICD)  
  Pacemaker  
  Loop Recorder  
  Watchman  
  CardioMEMS  
 LVAD  
  Abott (St Jude)  
  Medtronic  
  Biotronik  
  Boston Scientific

**Have you had valvular surgery?**  YES  NO

<input type="checkbox"/> Aortic Valve	<input type="checkbox"/> TAVAR	<input type="checkbox"/> Mechanical	<input type="checkbox"/> Bioprothetic (tissue)	<input type="checkbox"/> Repair
<input type="checkbox"/> Mitral Valve	<input type="checkbox"/> MitraClip	<input type="checkbox"/> Mechanical	<input type="checkbox"/> Bioprothetic (tissue)	<input type="checkbox"/> Repair
<input type="checkbox"/> Tricuspid Valve			<input type="checkbox"/> Bioprothetic (tissue)	<input type="checkbox"/> Repair
<input type="checkbox"/> Pulmonary Valve			<input type="checkbox"/> Bioprothetic (tissue)	<input type="checkbox"/> Repair

Have you had any previous **coronary stents**?  YES  NO Date: \_\_\_\_\_

Have you had any previous **coronary artery bypass**?  YES  NO Date: \_\_\_\_\_

Have you had any previous **peripheral (leg) stents**?  YES  NO Date: \_\_\_\_\_

Have you been evaluated for **Heart transplant**?  YES  NO Date: \_\_\_\_\_

If yes providers Name: \_\_\_\_\_

Have you been evaluated for **Kidney transplant**?  YES  NO Date: \_\_\_\_\_

If yes providers Name: \_\_\_\_\_

<b>Family History-</b> Please check all that apply		Are you adopted? <input type="checkbox"/> Yes	
<b>Father</b>	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Cause of Death / age:	<input type="checkbox"/> Cardiac Illnesses:
		_____	_____
<b>Mother</b>	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Cause of Death / age:	<input type="checkbox"/> Cardiac Illnesses:
		_____	_____

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Social History-** Please check all that apply

**Marital Status**             Single             Widower             Divorced

**Employment statuses**             Full Time             Part time             Student             Retired

**List your occupation**

**Are you a smoker**             YES     NO              If yes, how many daily?          

**Former Smoker**                      When did you quit?          

**Do you Drink Alcohol?**             YES     NO              If yes, how much?          

**Do you use illicit drugs?**             YES     NO              If yes, what drug and how often?          

**Have you recently been admitted to the hospital for cardiac symptoms?**     YES     NO

If yes, when and where? \_\_\_\_\_

**In the last year, have you had any cardiac testing?**     YES     NO

If yes, what, when and where? \_\_\_\_\_

**When was your last eye exam?** \_\_\_\_\_    Do you have:     Eyeglasses     Contacts

**Medication-** Please List any medication allergies or intolerances and reactions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please List all your current medications ( including supplements, vitamins and over the counter):

<b>Medication Name</b>	<b>Dose / Instruction</b>	<b>Medication Name</b>	<b>Dose / Instruction</b>
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Review of Systems

**Please check all that apply**

- |                                    |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Constitutional:</b>             | <input type="checkbox"/> Weight Loss                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Weight Gain                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Fatigue                                                                                                                                                                                                                                                                                                                                                        |
| <b>Cardiovascular:</b>             | <input type="checkbox"/> Angina, Chest Pain<br><input type="checkbox"/> Abnormal EKG<br><input type="checkbox"/> Heart Attack<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Congenital Heart defects<br><input type="checkbox"/> Varicose <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Abnormal blood pressure<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> Edema, Swelling in legs or feet<br><input type="checkbox"/> Edema, Swelling in abdominal<br><input type="checkbox"/> Claudication issues<br><input type="checkbox"/> Restless legs <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Abnormal heart rate<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Arrhythmia<br><input type="checkbox"/> Passing out or Black-out Spells<br><input type="checkbox"/> Leg pain <input type="checkbox"/> R <input type="checkbox"/> L<br><input type="checkbox"/> Leg discoloration <input type="checkbox"/> R <input type="checkbox"/> L |
| <b>Respiratory:</b>                | <input type="checkbox"/> Cough<br><input type="checkbox"/> COPD                                                                                                                                                                                                                                                        | <input type="checkbox"/> Coughing up blood<br><input type="checkbox"/> Asthma                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Pneumonia                                                                                                                                                                                                                                                                                                      |
| <b>Ear, Nose and Throat (ENT):</b> | <input type="checkbox"/> Difficulty hearing<br><input type="checkbox"/> Bleeding Gums                                                                                                                                                                                                                                  | <input type="checkbox"/> Ringing in ears<br><input type="checkbox"/> Sore Throat                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Vertigo<br><input type="checkbox"/> Allergies                                                                                                                                                                                                                                                                                                                  |
| <b>Gastrointestinal:</b>           | <input type="checkbox"/> Heartburn<br><input type="checkbox"/> Change in bowel movement<br><input type="checkbox"/> Abdominal Pain                                                                                                                                                                                     | <input type="checkbox"/> Nausea/Vomiting<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Hemorrhoids                                                                                                                                                                                                                                      | <input type="checkbox"/> Blood in Stool<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Ulcers                                                                                                                                                                                                                                                                         |
| <b>Genitourinary:</b>              | <input type="checkbox"/> Pain while Urinating                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Burning while Urinating                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Difficult Urinating                                                                                                                                                                                                                                                                                                                                            |
| <b>Hematologic:</b>                | <input type="checkbox"/> Bruising Easily                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Anemia                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Enlarged Glands                                                                                                                                                                                                                                                                                                                                                |
| <b>Musculoskeletal:</b>            | <input type="checkbox"/> Arthritis<br><input type="checkbox"/> Back Pain<br><input type="checkbox"/> Joint Pain                                                                                                                                                                                                        | <input type="checkbox"/> Decreased Motion<br><input type="checkbox"/> Muscle Pain<br><input type="checkbox"/> Joint stiffness                                                                                                                                                                                                                                  | <input type="checkbox"/> Gout<br><input type="checkbox"/> Neck Pain                                                                                                                                                                                                                                                                                                                     |
| <b>Skin:</b>                       | <input type="checkbox"/> Rash or Sores                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Itching/Burning Skin                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Psoriasis                                                                                                                                                                                                                                                                                                                                                      |
| <b>Neurological:</b>               | <input type="checkbox"/> Dizziness<br><input type="checkbox"/> Numbness<br><input type="checkbox"/> Spasticity (Spasm)<br><input type="checkbox"/> Speech impairment                                                                                                                                                   | <input type="checkbox"/> Seizures<br><input type="checkbox"/> Tremor<br><input type="checkbox"/> Memory Loss<br><input type="checkbox"/> Difficulty with walking                                                                                                                                                                                               | <input type="checkbox"/> Weakness<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Difficulty with balance                                                                                                                                                                                                                           |
| <b>Psychiatric:</b>                | <input type="checkbox"/> Anxiety                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Depression                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Insomnia                                                                                                                                                                                                                                                                                                                                                       |

**Patient or authorized person's signature:** \_\_\_\_\_