

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#: _____

EMERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)

Name: _____ Phone _____ Relationship: _____

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: _____

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.

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Ok to leave detailed message

Ok to leave detailed message

Ok to leave detailed message

Leave message with call back number only

Leave message with call back number only

Leave message with call back number only

Ok to mail to my home address listed above

Ok to E-mail to «PatientEmail»

Ok to sign up for patient portal

I have a Power of Attorney (POA)

Name: _____

I have an Advance Directive (Living Will)

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: _____

Medical History- Please list past medical diagnosis (illnesses & Conditions)			
Diagnosis	Date	Diagnosis	Date

Previous Surgery- Please list any surgeries			
Surgery	Date	Surgery	Date

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: _____

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

Patient Name: _____

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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):

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

Patient Name: _____

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Review of Systems

Please check all that apply

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

Patient or authorized person's signature: _____