CARDIAC CLINIC

Patient Information Sheet

All information below must be completed for billing purposes

Patient's legal name _____ SS#: _____

Date of birth _____ Age _____ Sex _____ Marital status _____

Address _____

City _____ State _____ Zip Code _____

Home phone _____ Cell phone _____ Work phone _____

Email address _____

Place of employment _____

Name of spouse/Emergency contact _____ Phone _____

Primary Care Physician _____ Phone _____

Race:

☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ More than one Race
☐ Native Hawaiian/Other Pacific Islander
☐ Refuse to Report
☐ White

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐Refuse to Report

Preferred Language:

☐ English
☐ Spanish
☐ Portuguese
☐ Other: _____

Name of Primary Insurance _____

Policy Holder Name _____ Relationship to Patient _____

Date of Birth _____ SS# _____

Policy ID # _____ Group # _____

Name of Secondary Insurance _____

Policy Holder Name _____ Relationship to Patient _____

Date of Birth _____ SS# _____

Policy ID # _____ Group # _____

(Copies of all insurance cards and driver's license must be provided)

I acknowledge that the information listed above is true and correct.

Patient signature _____ **Date** _____

Patient Name: _____ **Account#** _____ **Date:** _____

New Patient Questionnaire

Reason for visit? _____

Were you referred by another physician? ☐ Yes ☐ No Name of Physician: _____

Have you had any recent cardiac testing? ☐ Yes ☐ No

If yes, circle type of testing… Echo / Nuclear stress testing / Holter monitor / Carotid Doppler / _____

Recent hospitalizations? ☐ Yes ☐ No If yes, where? _____ When? _____

Do you drink caffeinated beverages ☐ Yes ☐ No If yes, how many cups/glasses per day? _____

Have you ever smoked? ☐ Yes ☐ No If yes, do you currently smoke? ☐ Yes ☐ No # of packs per day? _____

If you have smoked in the past, how much did you smoke per day? _____ When did you quit? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, _____ glasses ☐ Socially ☐ Weekly ☐ Daily

Have you had any past surgeries? ☐ Yes ☐ No (If yes, please list the surgery and date in the space provided below)

_____ _____

_____ _____

_____ _____

Are you currently taking any medications? ☐ Yes ☐ No (If yes, please list medications in the space provided below)

_____ _____

_____ _____

_____ _____

Please provide us with a brief family history below:

Mother: ☐ Alive & well History of: ☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Blood pressure ☐ Deceased (age) _____ (cause) _____

Father: ☐ Alive & well History of: ☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Blood pressure ☐ Deceased (age) _____ (cause) _____

Sibling(s): ☐ Alive & well History of: ☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Blood pressure ☐ Deceased (age) _____ (cause) _____

Other: _____

_____

_____

_____

_____

Cardiac Clinic appreciates the confidence you have shown in choosing us to provide for your health care needs.

Notice of privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice.

_____
Patient Initials

Consent for Treatment & Authorization to Release Information

I hereby authorize Cardiac Clinic to perform or have performed upon me appropriate assessment and treatment procedures as ordered by my treating physician. I further authorize Cardiac Clinic to disclose pertinent information for the purpose of continuity of care to other treating physicians and/or hospitals. In addition, I understand that it is sometimes necessary to submit additional information to my insurance carrier to process my claims for payment.

_____
Patient Initials

Cancellation / No-Show Policy

We understand you may occasionally miss a routine appointment due to an emergency or other obligation. However, if you know you will be unable to keep your scheduled appointment, we ask that you notify us as soon as possible so that we may accommodate another patient in your absence.

Due to the limited time slots for diagnostic testing done in the office, we urge patients to notify the office 48-hours in advance if you are unable to keep your scheduled appointment or charges may apply.

_____
Patient Initials

Statement of Patient Financial Responsibility

The services you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full. As a courtesy, we will bill your insurance carrier on your behalf.

If you do not have health insurance or if your health insurance terminates/cancels, you will be responsible for payment of the services rendered. Self-pay patients are expected to pay for each visit at the time of service unless a written and signed payment agreement is in place with Cardiac Clinic.

Most health insurance carriers require the patient to pay a co-pay and/or deductible for services rendered. Your Co-pay is expected and will be collected at the time of service for EACH VISIT. Many insurance companies have additional stipulations that may affect your coverage and out of pocket expenses. You are responsible for any unpaid balances, based on your contractual obligation with your insurance carrier.

I have read the above policies regarding my financial responsibility to Cardiac Clinic. I certify that the information I have provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Cardiac Clinic for cardiology and/or electrophysiology services provided to me by Cardiac Clinic. Should my insurance company send payment to me for services rendered by Cardiac Clinic, I agree to forward the endorsed check immediately to Cardiac Clinic.

_____ _____
Patient Signature **Date**

Cardiac Clinic authorization for disclosure of PHI to families/legal guardian

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information: **Cardiac Clinic**
B. Person(s) authorized to receive the information/instructions/results pertaining to your treatment:
   1. _____ DOB: _____
   2. _____ DOB: _____
   3. _____ DOB: _____
   4. _____ DOB: _____
C. Specific description of the information that may be used or disclosed (including dates):
   ➔
D. Specific description of how the information will be used:
   To assist with the plan of treatment between the above listed patient and Cardiac Clinic.
E. Authorization to leave results and messages regarding appointments and care, with family members listed above or on voicemail.
   ➔ **Please circle: YES** or **NO**

1) I understand that this authorization will expire on _____.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time **by notifying Cardiac Clinic in writing.**
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

☒_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Note:

You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/15" or, if your entire medical record is included, "all health information").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).

You have the right to know who is going to use it and what it is going to be used for (e.g., John Smith, PhD / Research).

You have a right to receive a copy of this form.

CARDIAC CLINIC NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 01,2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Trish Persaud. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information, when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ 1.00 for each page and the staff time charged will be $25.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Cardiac Clinic

Privacy Officer: Trish Persaud

Telephone: 407-933-1423 Fax: 407-933-7901

E-Mail: n/a

Address: 311 West oak Street

Kissimmee, Florida 34741