ST. LUKE HEART INSTITUTE

Thomas Mathews, M.D., F.A.C.C.

Board Certified Cardiologist
Interventional Cardiology
14533 Cortez Blvd.
Brooksville, Fl 34613
352-597-2008 352-597-2010 FAX 352-597-2070

Name_____ Date of Birth_____ SS #_____

Address_____ City, State, Zip_____

Phone( )_____ Cell ( )_____ Email Address_____

Age___ Male ( ) Female ( ) Communication preference Email ( ) Phone ( )Mail ( )None ( )

Occupation_____ Employer_____ Work Phone ( )_____

In Emergency Notify _____ Relationship_____ Phone ( )_____

Ethnicity		Preferred Language		Race		Smoking Status	
Non-Hispanic	( )	English	( )	African American	( )	Never Smoked	( )
Hispanic	( )	Spanish	( )	Asian	( )	Previously Smoked	( )
Other	( )	Other	( )	Caucasian	( )	Currently Smoke	( )
				Native American	( )	Packs per day	_____
				Alaskan	( )	Type of Tobacco	_____
				Hawaiian/Pacific Islander	( )		
				Other	( )		

Referring Physician_____ Phone ( )_____

Insurance

Medicare#_____ Private Insurance Carrier_____ ID#_____

Subscriber Name_____ Relationship_____ Date of Birth_____

Does your policy require precertification? Yes( ) No( ) Second Opinion? Yes( ) No ( )

Failure to answer the above questions accurately could result in patient responsibility for the BILL IN FULL

CONSENT FOR MEDICAL CARE ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

- I hereby authorize the undersigned physician to provide any medical treatment which his/her judgement is proper and necessary
- I authorize use of this form in all my insurance submissions
- I authorize release of Information to all my Insurance Companies
- I understand I AM RESPONSIBLE for my bill
- I authorize my doctor to act as my agent in helping me obtain payment from my Insurance companies
- I authorize payment directly to my doctor
- I permit a copy of this authorization to be used in place of the original
- I have received a copy of the office payment policy
- I have received a copy of the patient's bill of rights
- I will be responsible for follow up care as recommended
- I have received a copy of the Practice Private Policy

SIGNED(Patient,Guardian,Insured)_____

WITNESSED_____ DATE_____

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PATIENT NAME_____ DATE OF BIRTH_____

PHYSICIANS:

Primary Care_____ Cardiologist_____

Oncologist/Cancer_____ Neurologist_____

Urologist_____ GYN/OB_____

Other_____

ADVANCED CARE PLAN:

Living Will Yes ( ) No ( ) Health Care Surrogate Yes ( ) No ( )

Surrogate Name_____

Recent Falls? Yes ( ) No ( ) How many in the last 12 Months?_____

Injury:_____

Date reviewed with patient/Medical Assistant Initials_____

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PATIENT NAME_____ **DATE OF BIRTH**_____

PATIENT MEDICAL CONDITIONS:

___Anxiety/depression
___Arthritis
___Liver disease/hepatitis
___Hypertension
___HIV___STD
___Kidney disease
___Elevated cholesterol/triglycerides
___Anemia
___Heart disease/Heart attack
___Obesity: Counseling/Information
___Thyroid Disease
___Other
___Lung disease
___Cancer
___Diabetes
___Impotence
___DVT

Please explain above choices:

_____

FAMILY HISTORY:

___Alcohol use
___Heart Disease
___Arteriosclerosis
___Hypertension
___Stroke
___AAA
___Diabetes
___Cancer
___Other

Please explain above choices:

_____

PROCEDURES:

___PAP ___MAMMMO ___COLONOSCOPY ___PROSTATE/PSA ___CHEST X-RAY

SURGERIES:

_____Type	_____Date	_____Surgeon	_____Facility
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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PATIENT NAME_____ GENDER ___M ___F

REFERRING PHYSICIAN_____ PHONE_____

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR Yes ( ) No ( )

TOBACCO USE HISTORY
( ) Never Smoked
( ) Current Smoker Amount _____daily How long _____
( ) Former Smoker Amount _____ Year Quit_____ Total years smoking_____

ALCOHOL USE HISTORY
( ) Nondrinker
( ) Social Alcohol
( ) Alcohol drinker Amount/frequency_____

ALLERGIES
TO MEDICATIONS (Please indicate severity of reaction)

_____	( ) Mild	( ) Moderate	( ) Severe
_____	( ) Mild	( ) Moderate	( ) Severe
_____	( ) Mild	( ) Moderate	( ) Severe
_____	( ) Mild	( ) Moderate	( ) Severe
_____	( ) Mild	( ) Moderate	( ) Severe

FOODS

_____	( ) Mild	( ) Moderate	( ) Severe
_____	( ) Mild	( ) Moderate	( ) Severe
_____	( ) Mild	( ) Moderate	( ) Severe

ENVIRONMENTAL

_____	( ) Mild	( ) Moderate	( ) Severe
_____	( ) Mild	( ) Moderate	( ) Severe

CURRENT MEDICATIONS (Please use back of form for additional medications)

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

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RELEASE OF CONFIDENTIAL INFORMATION

I _____

SS #_____ Date of Birth _____

Authorize _____

To release information from my medical records including information of psychological, psychiatric, alcohol or drug related nature, HIV antibody test results and AIDS records to Dr. Thomas Mathews, M.D., F.A.C.C.

I understand that this content shall be valid for a period of one year from the date of the authorization and may be revoked at any time upon written notice.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42 CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

_____
Patient Signature

_____
Date of Signature

_____
Witness

RELEASE OF CONFIDENTIAL INFORMATION

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I,_____, hereby authorize ST. LUKE HEART INSTITUTE, INC. to use the following protected health information to:

ST. LUKE HEART INSTITUTE, INC.

[Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

This protected health information is being used for the following purposes:

Medical Records Billing Records _____ _____

I authorize this office to leave messages on my voice mail or answering machine. ( ) Yes ( ) No.

I authorize this office to leave messages with my spouse. ( ) Yes ( ) No.

I authorize this office to leave messages with my children. ( ) Yes ( ) No.

I authorize this office to leave messages if my tests are normal. ( ) Yes ( ) No.

I acknowledge that I have received a copy of this office's HIPAA privacy notice. ( ) Yes ( ) No.

I understand that I have the right to revoke this authrization, in writing, at any time by sending such written notification to:

ST. LUKE HEART INSTITUTE, INC.
14566 Cortez Boulevard
Brooksville, FL 34613

I understand that a revocation is not effective to the extent that ST. LUKE HEART INSTITUTE, INC. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

ST. LUKE HEART INSTITUTE, INC. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

1. Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
2. Refuse to sign this authrization.

_____ _____
Signature of patient or Personal Representative Date

_____ _____
Printed name of patient or Personal Representative Description of Representative's Authority