PRESTIGE CARDIOLOGY CONSULTANTS, LLC
8095 Spyglass Hill Road Suite 105
Melbourne, FL 32940

******MANDATORY INFORMATION TO FILE INSURANCE CLAIM IN BOLD PRINT******

Name: ____ **Date:** ____________________
First Middle Initial Last

Birth Date: _____/_____/_____ **Age:** __________ **Sex: M** ____ **F** ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ American Indian ☐Asian ☐Native American ☐Black or African American ☐ White ☐ Hispanic
☐ Other Race ______________________

Ethnicity: ☐ Hispanic ☐Not Hispanic

Language: ☐ English ☐ Indian ☐Spanish ☐Russian ☐ Thai ☐Other:_____________

Social Security Number: ______________________________

Street Address: ____

City: ____________________________ State: _________________ Zip: _______________________

Home Phone Number: ____________________________ Cell Number: ______________________

Employer: __________________________________ Work Phone Number: _______________________

Primary Care Physician: _____________________________ Phone number:___________________________

Referring Physician: ____

Pharmacy: __________________________________ Phone number: ___________________________

Lab Company: _______________________________

***************************************INSURANCE INFORMATION**

Primary Insurance: ____

Is the policy in your name? ☐ Yes ☐ No **If No, who is the policy holder?** _____________________

Policy holder's DOB: _____/_____/_____ **Policy #**: ____________________**Group #**: ____________________

Employer: ____

Secondary Insurance: ____________________________ Is the policy in your name? ☐ Yes ☐ No

If No, who is the policy holder? ____

Policy holder's DOB: _____/_____/_____ **Policy #**: ____________________**Group #**:____________________

Employer: ____

In Case of Emergency:
Name of Relative or Friend: ______________ Relationship to patient:______________ Phone #:______________

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Patient Name: ______________________________ Date:________________________

TOBACCO USE:
Do you currently use Tobacco products? ☐ YES ☐ NO
Total years smoked ___________ Years stopped________________
Indicate the quantity per day:
Cigarettes___________ Cigars__________ Chewing tobacco__________

ALCOHOL/DRUG USE:
Do you currently consume alcoholic beverages? ☐ YES ☐ NO
If yes, indicate the quantities consumed per day: Beer: ________ Wine:________ Distilled spirits:________

Have you used drugs other than those for medical reasons in the past 12 months? ☐ YES ☐ NO
Have you ever been treated for drug or alcohol addiction? ☐ YES ☐ NO

CAFFIENE USE:
Do you currently use caffeine products? ☐ YES ☐ NO
How often? _____________ How much? ________

EXCERSICE:
Do you currently exercise? ☐ YES ☐ NO
Frequency: ___________________________
Type of activity:_______________________

REVIEW OF SYSTEMS: Please check all that apply CURRENTLY affecting you today

General/Constitutional: ☐ Chills ☐ Fever ☐ Night sweats ☐ Weight gain ☐ Weight loss

Opthalmologic: ☐ Discharge ☐ Red eyes

Ear/Nose/Throat: ☐ Decreased hearing ☐ Sore throat ☐ Swollen glands

Endocrine: ☐ Fatigue ☐ Cold intolerance ☐ Heat intolerance ☐ Excessive thirst ☐ Weight loss

Respiratory: ☐ Cough ☐ Shortness of breath ☐ Sputum production ☐ Wheezing

Cardiovascular: ☐ Cold sweats ☐ Chest pain at REST ☐ Chest pain on EXERTION ☐ Leg swelling ☐ Palpitations ☐ Fainting ☐ Irregular heart beat

Gastrointestinal: ☐ Abdominal pain ☐ Bloody stool ☐ Diarrhea ☐ Difficulty swallowing ☐ Heart burn ☐ Vomiting blood ☐ Nausea ☐ Vomiting

Genitourinary: ☐ Blood in urine ☐ Difficulty urinating ☐ Frequent urination ☐ Pain with urination

Musculoskeletal: ☐ Leg cramps ☐ Painful joints ☐ Weakness

Peripheral Vascular: ☐Varicose veins ☐Cold extremities ☐ Pain/cramping in legs after exertion ☐ Ulceration of feet

Skin: ☐ Discoloration ☐ Dry skin ☐ Itching ☐ Rash ☐ Scars

Neurological: ☐ Balance difficulty ☐ Dizziness ☐ Headaches ☐ Focal weakness ☐ Memory loss ☐ Tremors ☐ Numbness/Tingling

Psychiatric: ☐ Anxiety ☐ Depressed Mood

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PATIENT HEALTH HISTORY

Name: ____ **Date:** ____________________

FAMILY HISTORY:

	Age	Alive	Deceased	Cause of Death	Medical History
Father					☐ Heart Attack ☐Coronary Artery Disease ☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Mental Illness
Mother					☐ Heart Attack ☐Coronary Artery Disease ☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Mental Illness
Sibling Brother Sister					☐ Heart Attack ☐Coronary Artery Disease ☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Mental Illness

MEDICAL HISTORY:

PROBLEM LIST:
Please CIRCLE all that apply and the DATE you were diagnosed

Anemia
Arthritis
Asthma
Blood disorder
COPD
Diabetes mellitus type 1
Diabetes mellitus type 2
Epilepsy
Glaucoma
Gout
Heart attack
Heart failure
Hemophilia
Hepatitis
Herpes simplex
High blood pressure
Hyperlipidemia
Irritable Bowel syndrome
Mental disorder
PVD – peripheral vascular disease
Prostate carcinoma
PVD – peripheral vascular disease
Rheumatic Fever
Scarlet Fever
Seizures
Sickle cell anemia
Skin cancer
Stroke
TIA
Thyroid disease
Tuberculosis
Other: ______________________________

Please list all medications you are currently taking, the strength and frequency.

____
____
____
____
____
____
____
____

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Please list all medications you are ALLERGIC to and what the reaction is.

____
____
____
____

Are you allergic to Latex? ☐ YES ☐ NO

Please list all **Surgeries** including Heart Catheterizations, Heart Pacemaker or Hernia Repair and when they occurred: ____
____
____
____
____
____

Height: ______________________ Weight:________________________________

Have you ever seen a Cardiologist Before? ☐ YES ☐_NO

If yes, who? ______________________________________ Date: _______________________________

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HIPAA AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I hereby give my consent to Prestige Cardiology Consultants to provide Medical treatment to myself.

I authorize the doctor to release any information, including the diagnosis and the records of any treatment rendered to myself during the period of such care to third party payers and/or health care practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group, the insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I also understand that I will be held responsible for any services not paid within 60 days of treatment. It is my responsibility to follow-up with my insurance carrier regarding claim status. I agree to pay collection costs and reasonable fees incurred while attempting to collect on any future outstanding balances.

I understand that my consent is not needed if the law requires Prestige Cardiology Consultants may need to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease and potential bodily harm to myself or others).

I understand that I have the right to review Prestige Cardiology Consultants privacy notice to request restrictions be put on the use of my information, and revoke my consent at a later date.

I agree if my insurance requires prior authorization, I must obtain a referral from my Primary Care Physician prior to all office visits and/or all procedures done in our facility. Services provided without prior authorization and/or services not covered by my insurance will be my responsibility.

I, the undersigned, hereby consent to the following treatment: administration and performance of all treatments, administration of any needed anesthetics, performance of such procedures as my be deemed necessary or advisable in the treatment of this patient, use of prescribed medication, performance of diagnostic procedures/tests, cultures, biopsies, and surgery, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees. I fully understand that this is given in advance of any specific diagnosis or treatment. I intent this consent will remain in full force until revoked in writing.

By signing my name below I certify that all the information on these forms is accurate and true to the best of my knowledge.

Patient Signature: ____ Date:________________________

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This form is optional and at the discretion of the patient.

HIPAA AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION TO INCLUDE HARD COPY MEDICAL RECORDS

(Authorization for Use or Disclosure of Protected Health Information is required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name: ____ Account #: ____________________

I authorize Prestige Cardiology Consultants to use and disclose specific Health and Medical information/medical records to the following people:

Name: ____________________________Relationship: _________________Phone number:______________

Name: ____________________________ Relationship:_________________ Phone number:_____________

Name: ____________________________Relationship: _________________Phone number:_____________

Name: ____________________________ Relationship:_________________ Phone number:_____________

Effective Period:
This authorization for release of information covers the period of healthcare:
❍ Today's date forward
❍ All past, present and future periods

Extent of Authorization:
a.) ❍ I authorize the release of my complete health record (including records relating to mental health care, cardiac health records and treatment of alcohol/drug abuse).
b.) ❍ I authorize the release of my complete health record with the EXCEPTION of the following information:
____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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

Advance Directive:

Do you have a "Living Will"? ☐ Yes ☐ No Do you have "Advanced Directives"? ☐ Yes ☐ No
Do you have a Power of Attorney? ☐ Yes ☐ No Do not resuscitate? ☐ Yes ☐ No
Patient Signature: ____ Date: ________________________________

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FINANCIAL POLICY

Co Payment Any co-payment required by your insurance carrier must be paid before service is rendered. This is an insurance requirement. You may be rescheduled if you can not pay your co-pay.

Estimates The exact cost of service can not be determined until after the provider has completed care. Any amount quoted is an **ESTIMATE ONLY**. Your actual bill may be higher or lower.

Insurance Prestige Cardiology participates in many health plans. We accept the contracted payment for our participation in these plans. You will be responsible for all balances unpaid by your health plan as the contract is between you and your insurance carrier. Although we may estimate what your plan may pay, your insurance carrier will make the final determination of your eligibility and benefits after they receive our claim.

We bill your insurance company as a courtesy and allow up to 60 days for the insurance company to pay. Regardless of the insurance coverage, the responsibility for payment of your account remains yours at all times. Please call your carrier for benefits and referrals.

It is always best to bring your current insurance card with you to each appointment. If we do not have complete billing information, you will be billed directly. Most insurance companies have time limits on claim submissions. You "waive" your insurance benefits if we can not confirm your insurance coverage.

A monthly statement will be sent to you after your insurance carrier sends their payment. We expect full payment on the account within 30 days. If the balance can not be paid within 30 days, we ask that you contact our office to make payment arrangements. If no arrangements are made, your account will be surcharged and given to a collection agency for collections and you will be discharged from the practice.

Returned There will be a $25.00 surcharge to your account if your check is returned to us for "**Insufficient Funds**." If this happens repeatedly, you may be discharged from the practice.

Copies Copying of medical records will be charged $1.00 per page.

Florida Statute 64B8-10.003 Costs of Reproducing Medical Records (1) Any person licensed pursuant to Chapter 458, Florida Statutes, required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the medical records. (2) Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: (a) for the first 25 pages, the cost shall be $1.00 per page. (b) For each page in excess of 25 pages, the cost shall be $0.25 cents.

Disability $25.00 will be charged for filling out any paperwork related to disability, handicapped parking, ect., The charge will be collected prior to the completion of the paperwork.

Medicaid You are responsible to bring your card to each visit and to keep your paperwork up to date to ensure eligibility. If there is a lapse in eligibility, you will be financially responsible for all services rendered.

Medicare You are responsible for informing us of a change from straight Medicare to a Medicare HMO program. In the event of a change in your insurance carrier that affects our ability to collect for services rendered, you will be liable for all fees for those services.

Print Name: ____________________

Patient's Signature: ____________________ **Date:** ____________________