Leesburg Office
803 E Dixie Ave, Leesburg, FL 34748

Lady Lake Office
809 CR 466 Suite 101-C, Lady Lake, FL 32159

Office: 352-530-2256 | Fax: 352-315-0069
www.cardiacsspecialtyinstitute.com

Welcome to Our Practice!

Please return the enclosed documents as soon as possible. Bring a current Medication List to your appointment, including over-the-counter medications.

If you have any questions, please do not hesitate to call us.

Thank you!

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PATIENT INFORMATION SHEET

Race:_____ Ethnicity:_____

Patient Name:_____ Male or Female (circle one)

Home Address: Northern Address:

_____ _____

_____ _____

_____ _____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Email Address:_____

Marital Status: Married, Divorced, Single, Widowed (Circle one)

Reason For Appointment:_____

Emergency Contact:
Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____

Referring Physician:
Physician Name:_____ Phone:_____
Reason for Referral:_____

Primary Care Physician:
Physician Name:_____ Phone:_____

Primary Insurance:
Insurance Company:_____ Phone:_____
Subscriber Number:_____ Group Number:_____

Secondary Insurance:
Insurance Company:_____ Phone:_____
Subscriber Number:_____ Group Number:_____

Pharmacy of Choice_____

Address_____Phone_____

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Patient Name: _____ **Date of Birth:_____**

MEDICATIONS:

Name of Medication	Dosage/Strength	Reason for Medication

ALLERGIES TO MEDICATIONS:	REACTION:

PAST/RECENT HOSPITALIZATIONS AND/OR SURGERIES		
Date: (M/D/Y)	**Location:**	**Reason for Hospitalization or Type of Surgery:**

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Patient Name: **Date:**

General	YES	Cardiovascular	YES	Endocrine	YES
Fever or chills		Chest Pain with activity		Night Sweats	
Recent weight change		Chest Pain at rest		Excessive thirst	
Fatigue		Heart skips beats		**Psychiatric**	**YES**
Heat or cold intolerance		Heart beats too fast		Depression	
Head or Neck	**YES**	Passing out spells		Anxiety	
Swelling in neck		High blood pressure		Nervous breakdown	
Prolonged hoarseness		Low blood pressure		Alcohol problems	
Sore throat		Heart Murmur		Drug problems	
Pain or Stiffness in neck		Bad heart valve			
Skin	**YES**	Rheumatic fever			
Rash, dryness, itching		Feet or ankle swelling			
Change in nails/skin color		Short of breath at rest			
Bleeding, bruising		Short of breath with activity			
Eyes	**YES**	Short of breath laying down			
Double, failing vision					
Pain or light sensitivity		**Lungs**	**YES**		
Gastrointestinal	**YES**	Cough			
Abdominal pain		Cough with sputum or blood			
Blood in stool		Wheezing			
Change in bowel		COPD			
Constipation		Dyspnea			
Diarrhea		Hemoptysis			
Heartburn		Pain while breathing			
Nausea		Chest congestion			
Vomiting					

Past and Family Medical History: Please check if you or your family have ever had any of the following:

If family, please circle F-Father, M-Mother, S-Sibling, G-Grandparent

	YOU	FAMILY	YOU	FAMILY
Hypertension		**F M S G**	Blood Clots	**F M S G**
Heart Disease		**F M S G**	Tuberculosis	**F M S G**
Stomach Ulcers		**F M S G**	Blood Disorder	**F M S G**
Seizure/Epilepsy		**F M S G**	Lupus	**F M S G**
Diabetes		**F M S G**	Stroke	**F M S G**
Cancer		**F M S G**	Thyroid Disease	**F M S G**
Renal Disease		**F M S G**	Liver Disease/Hepatitis	**F M S G**
PVD		**F M S G**	Aortic Aneurysm	**F M S G**
			CAD	**F M S G**

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Social History:

What is/was your occupation?_____Disabled: Yes or No

Drug Use:

Use one or more of the following:
(Please circle all that apply or None of the Above)

Marijuana ☐ Heroin ☐
Cocaine ☐ Illicit Prescriptions ☐
Crack ☐ None of the Above ☐

Smoking History:

Are you a current smoker: Yes or No ☐ ☐ Year Started:
If not current, are you a former smoker? Yes or No ☐ ☐ Year Quit:
If Current smoker:
Number of years: _____ Packs per day: _____

Drinking History:

Do you drink alcohol? ☐ ☐ Yes or No Year Started: Year Quit:
Beer:____ per ____ Wine: ____ per ____ Mixed Drinks: ____ per ____

Special Diet:

Are you on a special diet? Yes or No (If yes, please circle which one)
Low Salt ☐
Diabetic ☐
Calorie Limited ☐
High Fiber ☐
Low Cholesterol ☐

Exercise:

Do you exercise? Yes or No
Type of exercise_____ Daily or Weekly
Type of exercise_____Daily or Weekly

Patient Name:_____**Date:**_____

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Medical Release Form

Patient Name: _____ Date of Birth: _____ SS #: _____

I hereby authorize Cardiac Specialty Institute to obtain my medical records from:

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ State: ____ Zip Code: _____ City: _____ State: ____ Zip Code: _____

Phone: (___) _____ Phone: (___) _____

Fax: (___) _____ Fax: (___) _____

Information to be Disclosed: _____ Complete Chart Records - From:_____ To:_____

Purpose of Disclosure: ___ Continuing Care ___ Legal ___ Payment of Claim ___ School ___ Personal Use

Other: _____

_____

I specifically authorize the release of information relating to (For consent, initial each one.):

____ Substance House ___ HIV Related Information ___Behavioral Health ___Communicable Disease

Acknowledgement of Understanding:

1. I understand the expiration date of authorization is ONE year.
2. I understand that I may revoke this authorization at any time in writing. It will be effective on the date notified, except to the extent action that has already been taken.
3. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal privacy regulation.
4. I understand, by authorizing the use of disclosure of information, there will be no conditions placed on my healthcare or payment for my healthcare.
5. I understand that I have a right to receive a copy of this form after I have signed it.
6. understand that, in compliance with Flroida law, I may be required to pay a fee for the retrieval and photocopying of records and/or supervising inspection of those medical records.

Patient/Guardian Signature: _____ Date: ____/____/__

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HIPPA Patient Questionnaire

1. Please list the family members or other person(s), if any, when we may inform you about your condition and your diagnsosis (including treatment, payment, and health care options):

   Name: _____

   Name: _____

   Name: _____

2. Please list the family members or other person(s), if any, whom we may inform about your condition **ONLY IN AN EMERGENCY**:

   Name: _____

   Name: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home (Confidential Communications):

   Street Address: _____ City: _____ State: ___ Zip: _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**:

   _____ YES _____ NO

I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

Patient Signature: _____ Date: _____

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Notice of Privacy Practice Acknowledgement Form:

Our notice of privacy practice provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk.

You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment or healthcare operations as described in our notice. You have the right to revoke this consent in writing, except when we have already made releases in reliance on your prior consent.

Patient Name (Print):_____

Patient Signature:_____ Date:_____

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Patient Name_____ **Date of Birth**_____

Authorization to Release Information

I hereby authorize Cardiac Specialty Institute to disclose the specific information described below, only for the purpose and to the parties below.

Name_____

Name_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will no apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights regarding my protected health information. I understand that this information will be shared to plan direct and follow up patient care among multiple providers who may be involved in my treatment, directly and indirectly and to obtain payment from third policy payers. I acknowledge that I have received the notice of practices which contains a more complete description of the uses and disclosure of my health information. I understand that Cardiac Specialty Institute has the right to change its notice and privacy practices from time to time and I may contact Cardiac Specialty Institute at any time to address and obtain a new copy of the privacy practices. I also understand that I may request in writing that you restrict my private information that is used or disclosed to carry out treatment, payment of healthcare operations. I understand that Cardiac Specialty Institute is not required to agree to my requested restrictions and I understand and agree that I am bound by such restrictions.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature:_____ Date:_____

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Advance Directives

Advance Directives are a written statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Do you have any of the following Advance Directives? If so, please provide our office with a copy.

_____**Living Will:** Which is a written statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living.

_____**Health Care Surrogate Designation:** It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will.

_____**Do Not Resuscitate Order:** Which is a form or patient identification device developed by the Department of Health to identify people who do not wish to be resuscitated in the even of respiratory or cardiac arrest.

Patient Name:_____ Date:_____

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Billing and Insurance Procedure

1. I request that payment of authorized Medicare/Other Insurance Company benefits be made on my behalf to Cardiac Specialty Institute for services rendered from physicians or associates of Cardiac Specialty Institute. ( ) **Initials**

2. I authorize Cardiac Specialty Institute to release any medical information concerning me to my insurance company or its agents that is necessary to determine benefits or the benefits related to the payable services. I am aware that I am responsible for any deductables, co-insurance, and non-covered services. I understand this applies to all Medicare and commercial Insurance companies. ( ) **Initials**

3. I understand that payment is due at the time servies are rendered. All co-pays and deductibles will be collected. **( ) Initials**

4. Cardiac Specialty Institute will file a claim to the patient's insurance company. If the insurance company does not respond to the claim within 60 days from the date of billing, then the balance will become the patient's responsibility. The patient will receive a statement, and payment is due upon receipt. If payment has not been made within 30 days, further action will be taken. If the patient's deductible has not been met, or if the patient does not have insurance, arrangements must be made prior to seeing the medical doctor. **( ) Initials**

5. Medicare Patients: Cardiac Specialty Institute will file the patient's secondary insurance as a courtesy. Cardiac Specialty Institute will only bill one insurance company after Medicare. If we receive no response, the balance after Medicare pays will be the patient's responsibility. **( ) Initials**

6. If the patient has a HMO, obtaining authorization is the patient's responsibility for all visits, procedures, etc. If the patient chooses to be seen without an authorization, and the patient's insurance denies payment, the patient will be responsible for the entire bill. **( ) Initials**

Important Note: Please remember that the patien's coverage is a contract between the patient and the patient's insurance company. CARDIAC SPECIALTY INSTITUTE IS NOT PART OF THAT CONTRACT. Cardiac Specialty Institute files claims as a courtesy to the patient.

I, _____ (Print Name) has read and understand the above billing and insurance procedure.

_____ _____

Patient Signature Date

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Express and Informed Consent for Treatment

Patient Name **Date**

I hereby authorize the professional staff of Cardiac Specialty Institute to administer a health assessment and treatment.

I understand that I am responsible for paying the fees at the time services are rendered.

I understand that more information will be provided for me before any tests will be performed, at which time my informed consent will be completed.

I understand that my consent can be revoked orally or in writing prior to, or during, the treament period.

I understand that my records are confidential but there are some exceptions . Cardiac Specialty Institute agrees not to release any of my information to anyone other than staff of Cardiac Specialty Institute and physicians involved in my care without my written consent (protected by State and Federal law). I understand there are times when the law requires that information be shared with authorities. These times would include cases with physical or sexual abuse, neglect of children, eldered, or disabled persons, and/or expression of intent to harm one's self or others. If Cardiac Specialty Institute has knowledge of a communicable disease that can harm others, the State requires we report data for follow up sdtudy if Cardiac Specialty Institute receives a court order requiring that we release information.

Patient Signature Date