



Consultative and Interventional Cardiology and Vascular Diseases

FLORIDA HEART & VASCULAR ASSOCIATES, P.L.

Diplomate American Board of Internal Medicine
Board Certified in Cardiovascular Diseases

YOU MUST ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT

Dear New Patient,

Welcome to Florida Heart and Vascular Associates.

For your upcoming appointment with our doctors, we ask that you fill out this packet in it's entirety, prior to your visit. If you have any questions please give us a call at (813) 971-2424.

Enclosed are forms that we need you to complete prior to coming to our office.

There are several items we need you to bring for your appointment:

1. Any old cardiac records that include:
 - a. Bypass Records
 - b. Cardiac Catheterization / Angioplasty records and films if possible
 - c. Exercise Stress Test or Nuclear Stress Test report
 - d. Echo cardiogram report
 - e. Holter Monitor report
 - f. EKG (within the last year)
 - g. Chest X-Ray report (no films) (within the last year)
 - h. Blood Work report (including cholesterol) (within the last year)
 - i. If another physician is referring you to us please bring a copy of the last office visit note.
2. All medications in the original bottles
3. List of any drug allergies

***IF YOU REQUIRE AN AUTHORIZATION NUMBER FROM YOUR INSURANCE COMPANY, IT IS YOUR RESPONSIBILITY TO OBTAIN IT FROM YOUR PRIMARY CARE PHYSICIAN. WE ASK THAT YOU CALL TO VERIFY THAT WE HAVE RECEIVED YOUR AUTHORIZATION PRIOR TO YOUR APPOINTMENT.**



Payment Policy

2/16/2009

Thank you for choosing Florida Heart and Vascular Associates, PL as your cardiology care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payment and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered medically necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.
4. **Proof of insurance.** All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage charges.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay our claim in 45 days, the balance will automatically be billed to you.
7. **Non-payment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternate medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.
8. **Forms Completion.** There will be a \$25.00 charge for letters for which the physician and/or staff are requested to complete. Additionally there will be a \$10.00 per page charge for the following items:
 - a. Letter of Medical Necessity
 - b. Family Medical Leave Forms
 - c. Disability Forms
 - d. Application for handicapped parking permits and or license
 - e. 90 day prescription forms
 - f. Prior authorization of medication through an insurance company
9. **After-hours calls.** There will be a \$25.00 consultative charge for all after-hours calls that require a return phone consult from the physician or nurse practitioner. This will be billed to you personally. This is not reimbursable through your insurance company.
10. **No-show fees.** There will be a \$25.00 charge for appointments that are not cancelled within 24-hours in which you fail to attend; this fee may be up to \$100.00 if the appointment involves testing agents that are pre-ordered and thus wasted.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the reasonable and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Signature of Patient or Responsible Party: _____ Date: _____



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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Florida Heart and Vascular Associates, PL uses and discloses health information about you for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time from the front desk. If you have any questions you can contact us at (813) 971-2424.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physicians in this practice are specialists. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. We also may need to obtain hospital records to facilitate in your care.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurance company. The form will contain medical information such as a description of the medical service provided to you and the diagnosis used. Your insurance company needs this information to approve payment to us. We also may need to use your information for medical claim review or hearing if the review is denied in order to obtain payment for our services.

Health Care Operations

We are permitted to use or disclose your medical information for the purpose of health care operations which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional consultant to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law. In addition to this, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best healthcare is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. This includes, but is not limited to, fax transmissions. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or administrative decision maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by a law enforcement official, we may disclose medical information under limited circumstances provide that the information:

- *Is released pursuant to legal process, such as a warrant or subpoena;
- *Pertains to a victim of a crime and you are incapacitated;
- *Pertains to a person who has died under circumstances that may be related to criminal conduct;
- *Is about a victim of a crime and we are unable to obtain the person's agreement;
- *Is released because of a crime that has occurred on these premises; or
- *Is released to locate a fugitive, missing person, or suspect
- *Worker's Compensation, Inmates, Military, National Security and Intelligence Activities, Protection of the President, Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request under emergency circumstances.

To request a restriction, submit the following in writing (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the written request to the Privacy Officer. You may request in writing that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternate Means

You may request that we send communications of protected health information by alternative location. This request must be made in writing to the Privacy officer. We are required to accommodate only reasonable request. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact address/form.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- *Includes psychotherapy notes
- *Includes the identity of a person who provided information if it was obtained under the promise of confidentiality
- *Is subject to the Criminal Laboratory Improvements Amendments of 1988
- *Has been compiled in anticipation of litigation

Appointment Reminders, Treatment Alternatives, & Other Health-Related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. We will leave a voice message regarding the appointment, lab results, and test results unless you notify us otherwise in writing. We will not be responsible if your phone number or address changed and we were not notified by you or your representative. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

I have reviewed this office’s Notice of Privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of patient or personal representative

Date

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual’s acknowledgement, describe the good faith efforts made to obtain the individual’s acknowledgement and the reason(s) why the acknowledgement was not obtained.

Signature of Provider Representative

Date

Description of good faith effort: _____



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**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS
FROM MEDICAL PROVIDERS**

I hereby authorize Florida Heart and Vascular Associates, PL (“the practice”) to obtain any and all medical records concerning my care from any physician, hospital, or other health care professional that has provided medical care to me in the past.

I also hereby authorize the practice to release any and all medical records concerning my care to any physician, hospital, or other health care professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to my insurance company.

Patient Signature

Date

Printed Name

Date of Birth

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO
INDIVIDUALS/FAMILY MEMBERS**

In accordance with federal government privacy rules implemented through the Healthcare Portability Act (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize the practice to release any or all information concerning my medical care to any individual except as set forth below.

_____ I hereby give my permission for the practice to leave lab results and appointment reminders on my answering machine.

_____ I authorize the practice to verbally release any or all information concerning my medical care to the following individuals.

Name

Relationship to Patient

Name

Relationship to Patient

Patient Signature

Date

Witness

Date

Florida Heart and Vascular Associates, PL

Patient History

Name: _____ Account #: _____ Date: _____

PCP / Referring Physician: _____

Recent History (Why are you seeing the doctor?): _____

CURRENT CARDIAC SYMPTOMS

Chest Pain or angina Y / N
 Palpitations (feel heart beating hard) Y / N
 Short of breath (walking / lying flat) Y / N
 Swelling of feet, ankles or hands Y / N
 Lightheadedness, dizziness, or fainting Y / N
 Pain in legs when walking Y / N

PAST MEDICAL HISTORY

Have you ever been told that you had

Diabetes Y / N
 High Blood Pressure Y / N
 Cancer Y / N
 Stroke / Mini-Stroke / TIA..... Y / N
 Heart Attack / Angina Y / N
 Kidney Trouble Y / N
 Arthritis / Gout..... Y / N
 Convulsions / Seizures Y / N
 Bleeding Tendencies Y / N
 Serious Infections..... Y / N
 Lung Diseases / Asthma..... Y / N
 Heart Murmur / Valve Disease Y / N

ALLERGIC / IMMUNOLOGIC

Penicillin or other antibiotics Y / N
 Morphine, Demerol, or other Narcotics Y / N
 Aspirin or other pain remedies..... Y / N
 Iodine, Methiolate, or shell fish Y / N
 Drugs / Medications _____

Previous Cardiac Hospitalizations / Heart Catheterization / Heart Attacks / Surgeries

_____ Date: _____

_____ Date: _____

_____ Date: _____

Cardiac Diagnostic Tests / Echocardiogram / Stress Test / Holter Monitor / Other

_____ Date: _____

_____ Date: _____

_____ Date: _____

MEDICATIONS: (currently taking)

Name of Medicine	Dose	How Often?	Name of Medicine	Dose	How Often?
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

MEDICATION PROBLEMS / INTOLERANCE: _____

SOCIAL HISTORY

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

Religion: _____

Use of Tobacco: Never / Prev. quit in _____ / Current: Cigar / Pipe / Cigarettes Amount: _____

Use of Alcohol: Never / Moderate / Daily _____

Use of Drugs: Never / Type of drug / How often: _____

Use of Caffeine: Never / Moderate / Daily Amount: _____

Exercise Never / Moderate / Daily Type: _____ Amount: _____

FAMILY HISTORY

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers / Sisters	_____	_____	_____
1.	_____	_____	_____
2.	_____	_____	_____
Children	_____	_____	_____