M.D. _____ Date: _____

PATIENT INFORMATION FORM

Patient # _____

For office use only

Last Name _____ **First** _____ **Middle** _____

Date of Birth ____/____/_____ **Soc. Sec. #** _____-_____-_____ **Sex** ☐ M F **Marital Status** _____

Race: (Circle) African. Amer/Black | Amer. Indian/Alaskan Nat | Asian | Caucasian/White | Hawaiian/Pacific Islander | Other

Telephone Number: (Preferred): (____) _____ - _____ **(Secondary):** (____) _____ - _____

Address _____
Street Number and Name Apt. or Unit # City State Zip

Email _____ Permission to send newsletters/events by email: ☐ yes ☐ no

Northern Address _____
Street Number and Name Apt. or Unit # City State Zip

Referring Physician _____ **Phone** (____) _____ - _____

Primary Care Physician _____ **Phone** (____) _____ - _____

How did you hear about us: __Yellow Pages __Friend __Website Doctor: _____ Other: _____

➢ PRIMARY INSURANCE (Cards MUST also be presented at time of service)

Insurance Company _____

Insurance ID # _____ **Group #** _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ **Soc. Sec. #** _____-_____-_____ **Date of Birth** ____/____/_____

Address _____
Street Number and Name Apt. or Unit # City State Zip

Telephone Number: (Preferred): (____) _____ - _____ **(Secondary):** (____) _____ - _____

➢ SECONDARY INSURANCE *(If not applicable, please cross out section)*

Insurance Company _____

Insurance ID # _____ **Group #** _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ **Soc. Sec. #** _____-_____-_____ **Date of Birth** ____/____/_____

Address _____
Street Number and Name Apt. or Unit # City State Zip

Telephone Number: (Preferred): (____) _____ - _____ **(Secondary):** (____) _____ - _____

➢ ASSIGNMENT & RELEASE

I hereby authorize payment directly to Bradenton Heart Center of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. **I have also been given a copy of Bradenton Heart Center's Office & Financial Policy.**

Signature: _____ Date: _____

ATTN: MEDICARE PATIENTS – LIFETIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by the physicians of Bradenton Heart Center, P.A. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agent any information needed to determine these benefits for related services.

Signature: _____ Date: _____

Bradenton HEART CENTER

PATIENT MEDICAL AND FAMILY HISTORY

PATIENT NAME (LAST, FIRST, MI) _____ **DATE** _____

REASON FOR THIS EVALUATION (What specific questions do you want answered?)

DO YOU HAVE ANY ALLERGIES? □ YES □ NO

If yes, please list: _____

ALLERGY to IODINE or SHELLFISH? □ YES □ NO ALLERGY to IVP DYE? □ YES □ NO

PLEASE LIST **ALL** PREVIOUS SURGICAL PROCEDURES: **Continue on BACK if needed**

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Have you **EVER** had any of the following Cardiac Procedures?

STRESS TEST OF ANY KIND	**□ YES**	**□ NO**	**Month/Year:** _____
ECHOCARDIOGRAM	**□ YES**	**□ NO**	**Month/Year:** _____
ULTRASOUND OF THE LEGS	**□ YES**	**□ NO**	**Month/Year:** _____
CAROTID ULTRASOUND	**□ YES**	**□ NO**	**Month/Year:** _____
RENAL ULTRASOUND	**□ YES**	**□ NO**	**Month/Year:** _____
CARDIAC CATH	**□ YES**	**□ NO**	**Month/Year:** _____
PTCA (ANGIOPLASTY)	**□ YES**	**□ NO**	**Month/Year:** _____
STENTS	**□ YES**	**□ NO**	**Month/Year:** _____
CORONARY ARTERY BYPASS	**□ YES**	**□ NO**	**Month/Year:** _____
PACEMAKER IMPLANT	**□ YES**	**□ NO**	**Month/Year:** _____
DEFIBRILLATOR IMPLANT	**□ YES**	**□ NO**	**Month/Year:** _____
ABLATION	**□ YES**	**□ NO**	**Month/Year:** _____
VALVE REPAIR	**□ YES**	**□ NO**	**Month/Year:** _____
VALVE REPLACEMENT	**□ YES**	**□ NO**	**Month/Year:** _____
If Yes, □ Mechanical or □ Pig Valve			

Have you **EVER** had any of the following?

DIABETES	**□ YES**	**□ NO**	**GOUT**	**□ YES**	**□ NO**
ANEMIA	**□ YES**	**□ NO**	**ARTHRITIS**	**□ YES**	**□ NO**
STROKE	**□ YES**	**□ NO**	**HIATAL HERNIA**	**□ YES**	**□ NO**
CHEST PAIN	**□ YES**	**□ NO**	**ULCER**	**□ YES**	**□ NO**
PALPITATIONS	**□ YES**	**□ NO**	**GALLBLADER DISEASE**	**□ YES**	**□ NO**
HEART MURMUR	**□ YES**	**□ NO**	**THYROID DISEASE**	**□ YES**	**□ NO**
ABNORMAL EKG	**□ YES**	**□ NO**	**KIDNEY DISEASE**	**□ YES**	**□ NO**

RHEUMATIC FEVER	□ YES	□ NO	LIVER DISEASE	□ YES	□ NO
HIGH BLOOD PRESSURE	□ YES	□ NO	BOWEL DISEASE	□ YES	□ NO
BREATHING DIFFICULTY	□ YES	□ NO	CANCER	□ YES	□ NO
LIGHTHEADED/DIZZY	□ YES	□ NO	SKIN LESSIONS	□ YES	□ NO
HEART ATTACK	□ YES	□ NO	PSYCHIATRIC DISEASE	□ YES	□ NO
HIGH CHOLESTEROL	□ YES	□ NO	UNEXPLAINED WEIGHT	□ YES	□ NO

Do you currently use or have you previously used TOBACCO? □ YES □ NO

If YES, what type? (Please circle one) Cigarette Pipe Cigar Dip/Chew

If CURRENT User: How many years? _____ How many packs/amount per day? _____

If FORMER User: Age Started: ____ /Age Stopped: ____ How many packs/amount per day? _____

Do you drink ALCOHOL? □ YES □ NO

If YES, how often? (Please circle one) Everyday Occasional Never

Do you drink CAFFEINE? □ YES □ NO

If YES, how often? (Please circle one) Everyday Occasional Never

FAMILY HISTORY

Father Living? □ YES □ NO Age or Age @ Death: _____ Cause of Death? _____
Any Illnesses? _____

Mother Living? □ YES □ NO Age or Age @ Death: _____ Cause of Death? _____
Any Illnesses? _____

How many Brothers are living? _____ How many Brothers are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

How many Sisters are living? _____ How many Sisters are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____
How many Sons are living? _____ How many Sons are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

How many Daughters are living? _____ How many Daughters are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

ACTIVITY HISTORY

What kind of exercise do you do?

_____

_____

What is your main hindrance (if any) to exercising?

_____

_____

Bradenton
HEART CENTER

PATIENT CONSENT AND CONTACT FORM

Last Name _____ **First** _____ **Middle** _____

Date of Birth _____/_____/_____ **Soc. Sec. #** _____-_____-_____

I understand that as a part of my healthcare, Bradenton Heart Center originates and maintains health records describing my health history, symptoms, examination and test result, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

A basis for planning my care and treatment.
A means of communication among the many healthcare professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party payer can verify that services billed were actually provided.
A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

To object to the use of my health information for directory purposes.

To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.

To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have been given a copy of the Notice of Privacy Practices.

Does Bradenton Heart Center have permission to:

Send test results to your home? Yes □ No □

Leave the following information on your preferred answering machine/voice mail:

Appointment information Yes □ No □
Billing information Yes □ No □
Medical information Yes □ No □

Leave the following information on your secondary answering machine/voice mail:

Appointment information Yes □ No □
Billing information Yes □ No □
Medical information Yes □ No □

I agree that my Protected Health Information may be shared with the following people:

_____ Relationship: _____
Full Name

_____ Relationship: _____
Full Name

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Bradenton Heart Center.

Signature: _____ Date: _____

Authorization for Use/Disclosure of Protected Health Information

PATIENT NAME: _____ DOB: _____

PERSON(S)/ORGANIZATION AUTHORIZED TO PROVIDE THE INFORMATION (include phone/address):

_____

PERSON(S)/ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION (include phone/address :

Bradenton Heart Center, P.A., 2010 59th St. W., Ste 4200, Bradenton, FL 34209; 941-794-3999

INFORMATION TO BE RELEASED:

(Check ALL that apply) Date(s)

__ History & Physical Exam _____

__ Office Visits _____

__ Lab Reports _____

__ X-Ray Reports _____

__ Other _____ _____

I specifically authorize the release of information relating to:

__ Substance Abuse (including alcohol/drug use)

__ Mental Health (including psychotherapy notes)

__ HIV related information (including AIDS related testing

__ Genetic Testing

X _____
signature

PURPOSE OF DISCLOSURE:

__ Changing Physicians __ Consult/Second Opinion __ Continuing Care

__ Legal __ Other _____

This authorization will expire on _____ (NOTE: If left blank, it will expire 12 months from date signed).

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however the office has the right to deny the above request.
4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the organization that receives the information is not healthcare provider, plan or business associates (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and no longer be protected by Federal privacy regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

_____ _____ OR _____ _____

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

OFFICIAL USE ONLY:

INFORMATION RELEASED BY: _____ DATE RELEASED: _____

MEDICATION LIST

Patient Name _____ **Date of Birth** ____/____/_____

Please include all prescription and over-the-counter medications, including herbal products and vitamins.
Please update the form before every physician visit and bring the form to every visit.

	Medication	Dose	How Often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

BRADENTON HEART CENTER, P.A.
OFFICE AND FINANCIAL POLICY & AGREEMENT

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Scheduling and registration: We require you to provide your medical insurance card, photo identification, address, date of birth, social security number and phone number. If you receive health benefits through a spouse we require you to provide that person's address, date of birth, and phone number as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and may ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office of any changes at your next appointment.

Keeping Appointments for Consultation, Follow up or Testing: All appointments are very important to initiate and/or execute my treatment plan. During these appointments, my physician might order tests, review my plan of care, prescribe medication, or even discover and treat a serious health condition. If I don't show up for my appointment, or miss my appointment and fail to reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. (_____) Initial

In addition, I understand that missing or not showing up for my appointment creates a significant hardship for my physician and is not fair for other patients who would like to access cardiology services by my physician's practice. I will make every effort to notify my physician, his or her nurse or the scheduling team a minimal of 48 hours in advance of my appointment cancellation and reschedule missed appointments, as soon as possible. (_____) Initial

If you are unable to make your appointment due to a *bona fide* emergency no cancellation fee will apply provided you supply written documentation or proof of the emergency. In all other instances:

- A **"$25.00 no show cancellation fee"** will be charged, without exception, for un-kept office visit appointments not canceled 48 hours before the scheduled appointment time. (_____) Initial
- A **"$50.00 no show cancellation fee"** will be charged, without exception, for un-kept ultrasound appointments not canceled 48 hours before the scheduled appointment time. (_____) Initial
- A **"$100.00 no show cancellation fee"** will be charged, without exception, for un-kept nuclear stress testing appointments not canceled 48 hours before the scheduled appointment time. This test requires a daily purchase and delivery of pharmaceuticals that have a shelf life of only one day. (_____) Initial

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your coverage and responsibilities.

Authorizations: You are responsible to make sure all necessary referrals, pre-certifications or other required documentation are obtained prior to your appointment. Our team may help with this process in certain circumstances. If our team determines that your plan requires an authorization, and you do not provide such referral, authorization or certification, you may be required to sign a waiver in order to receive services or the appointment may be rescheduled.

Copayments: It is **our responsibility**, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is **your responsibility**, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. There will be a Service Charge on all returned checks.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account may be sent to a collection agency.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. Payment arrangements may be made on a case by case basis by contacting us and providing proof of financial hardship.

Medical Records: A fee of $1.00 per page for the first 25 pages and .25 for each additional page will be charged for a copy of your medical records for the purpose of transferring care or personal use. There is no charge for medical records that we are requested to forward by mail or fax to other treating physicians.

Form Completion: A fee of $20 will be charged for the completion of most forms (disability, FMLA, etc.)

Telephone Messages: Non-urgent telephone messages will be returned within 24 hours. If you have an urgent problem, please speak to our clinical department (do not leave a message).

Prescription Refills: Please call your pharmacy and ask them to send us an electronic request for a refill of your prescription(s). Once we receive this request please allow up to 48 hours for the request to be completed.

Patient Acknowledgment

I have read and understand the above agreement and agree to abide by the policies outlines above.

Signature: _____ Date: _____

For Office Use Only:

Patient Number: _____