CARDIOVASCULAR INTERVENTIONS, P.A.

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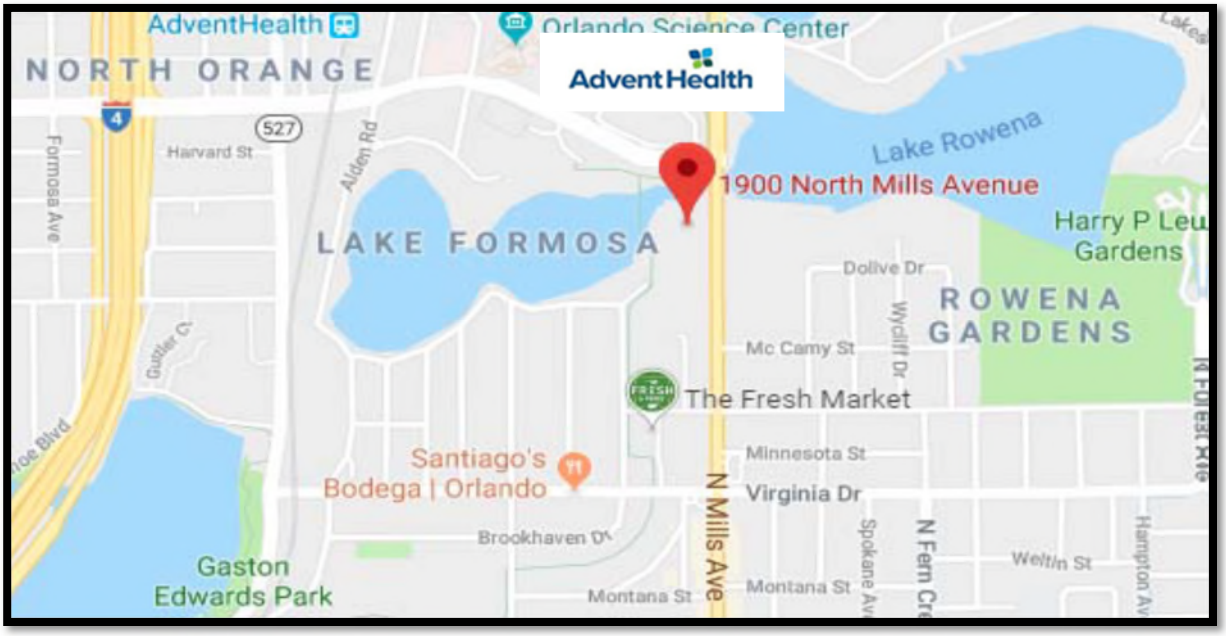
**Dear Patient:**

**Thank you for choosing Cardiovascular Interventions. P.A. as your health care provider. Welcome to our practice. We look forward to providing you the best cardiac care.**

**Your appointment is scheduled for:_____ at_____**

**Please plan on arriving 30 minutes prior to your appointment time to ensure that all required paperwork is completed. Due to the complexity of your comprehensive office visit, it is reasonable to allow for up to two hours for your appointment time. In order to expedite this process, you will need to bring with you the following:**

**[ ] New Patient Packet**
**[ ] Medical records: MUST be obtained a 5 days prior to your appointment date including primary care doctor/referring doctor, previous cardiologist records**
**[ ] Your insurance card (s)**
**[ ] Photo ID**
**[ ] Your referral or authorization from your primary care physician (if needed)**
**[ ] Medication bottles/medication list**
**[ ] Co-Pay/Self-Pay rates that may apply**




**1900 N. Mills Avenue • Suite 107• Orlando, FL 32803**

**"To provide the most comprehensive state-of-the-art cardiovascular care that is personalized and affordable with an emphasis on prevention."**

## CONSENT FOR CARE AND TREATMENT

**To The Patient:**

You have the right, as a patient, to be informed about your condition and the recommended medical and or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily accept the physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor, we will place your account with a collection agency which will leave you liable for any additional charges incurred.

## MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries, or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

**Printed Name:** _____ **Signature of Patient:**_____

# PATIENT DEMOGRAPHIC INFORMATION

## PATIENT INFORMATION (PLEASE COMPLETE ALL SECTIONS ON FORM)

FIRST NAME:_____ MIDDLE :_____ LAST NAME:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE:_____ CELL:_____ EMAIL: _____

PREFERRED CONTACT METHOD: □ HOME PHONE □ CELL PHONE □ WORK

SEX: □ MALE □ FEMALE

MARITAL STATUS □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

RACE: □ BLACK, AFRICAN AMERICAN □ ASIAN □ WHITE □ AMERICAN INDIAN, ALASKA NATIVE □ NATIVE HAWAIIAN, OTHER PACIFIC ISLANDER

## EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:_____ RELATIONSHIP TO PATIENT:_____

EMERGENCY CONTACT PHONE:_____

### NEXT OF KIN

NAME:_____ RELATIONSHIP TO PATIENT:_____

CONTACT PHONE:_____

## PRIMARY INSURANCE

PRIMARY INSURANCE NAME:_____

GROUP NUMBER:_____ POLICY NUMBER:_____

POLICY HOLDER NAME:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

## SECONDARY INSURANCE

SECONDARY INSURANCE NAME:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

POLICY HOLDER NAME:_____

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

## PHYSICIAN INFORMATION (PLEASE PRINT INFORMATION)

**PRIMARY CARE PROVIDER:**_____

**PHYSICIAN WHO REFFERED YOU TO OUR SPECIALIST:**_____

**PHONE:**_____ **FAX:**_____

## PHARMACY INFORMATION

**PHARMACY NAME:**_____

**PHARMACY PHONE:**_____ **FAX:**_____

**PHARMACY ADDRESS:**_____

## EMPLOYMENT INFORMATION

**COMPANY NAME:**_____

**EMPLOYER PHONE NUMBER:**_____**EXTENSION:**_____

**ADDRESS:**_____

**CITY:**_____ **STATE:**_____ **ZIP:**_____

## TOBACCO HISTORY

**HAVE YOU EVER SMOKED? [ ] YES [ ]NO**

**IF A FORMER SMOKER, HOW LONG?**_____

**WHAT WAS YOUR QUIT DATE?** _____

## SUBSTANCE HISTORY

**DO YOU DRINK ALCOHOL? [ ] YES [ ] NO**

**HAVE YOU USED DRUGS OTHER THAN THOSE REQUIRED FOR MEDICAL REASONS? [ ] YES [ ] NO**

**IF YES, STATE TYPE:**_____

CardioVascular Interventions, P.A.

## MEDICAL RECORDS RELEASE FORM

| LAST | FIRST | MI | Date of Birth |
|---|---|---|---|
| | | | |

I hereby authorize Cardiovascular Interventions, P.A. to release/obtain any and all medical records concerning my care from any physician, hospital, or other healthcare professional.

# Please have this form completed and returned Today!!!!

## Primary Physician

Primary Physician: _____ Phone:_____ Fax:_____

Primary Physician: _____ Phone:_____ Fax:_____

## Previous Cardiologist

Primary Physician: _____ Phone:_____ Fax:_____

Primary Physician: _____ Phone:_____ Fax:_____

## Other Physician

Other Physician: _____ Phone:_____ Fax:_____

Other Physician: _____ Phone:_____ Fax:_____

## Hospital

Hospital:_____ Location:_____ Fax:_____

Hospital:_____ Location:_____ Fax:_____

## For Office Only-Requesting Records

Please Fax available records to **(407) 894-2364** prior to the patient's schedule appointment to assist us in properly evaluating this patient for continue of care:

Complete Records: _____ Consultation/ Progress Notes: _____ All Most Recent Records: _____

Path/Operative Reports:_____ Lab Testing:_____ All Diagnostic Test Results:_____

**Patient Signature: _____ Date:_____**

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

## ALLERGY HISTORY

**Have you ever had an allergic reaction to any medication? [ ] YES [ ] NO**

**If Yes, please list medication and the reaction.** _____

_____

## CURRENT MEDICATIONS

**Please list any medication (Prescriptions and non-prescriptions) you are currently taking, including vitamins and aspirin. Please use a separate sheet if necessary.**

| MEDICATION | DOSAGE | NUMBER TAKEN DAILY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## PMH- HEALTH SUMMARY

| SYSTEM | YES | NO | DATE OF RESULT/EXPLAIN |
|---|---|---|---|
| Coronary Disease/ Heart Attack/Angina | | | |
| Congestive Heart Failure | | | |
| Atrial Fibrillation | | | |
| Other Arrhythmias | | | |
| Pacemaker/ICD | | | |
| Heart Valvular Disorder | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Peripheral Vascular Disease | | | |
| Diabetes | | | |
| Renal Failure | | | |
| GI Ulcer/ Bleeding | | | |
| Pulmonary Disease | | | |
| Stroke/TIA | | | |
| Sleep Disorder | | | |
| Anemia/Cancer of Blood | | | |
| Other Cancer | | | |
| Psychiatric Care | | | |

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

**HIPAA COMPLIANT**

I, or my authorized representative, hereby authorize Cardiovascular Interventions P.A and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record through signature below.

In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

**Initial**

_____This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION.**

_____If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.

_____I have the right to revoke this authorization at any time by writing to Cardiovascular Interventions P.A. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

_____I understand that signing this authorization is voluntary. My treatment, payment, enrollment in Cardiovascular Interventions P.A., or eligibility benefits will not be conditioned upon my authorization of disclosure.

_____Information disclosed under this authorization might be redisclosed by the recipient, and the redisclosure may no longer be protected by federal or state law.

_____This authorization does not authorize you to discuss my personal health information and insurance record with anyone other than the person authorized.

**Print Name of Patient or Authorized Representative:** _____

**Signature of Patient or Authorized Member:** _____

**Date:** _____ **Relationship:** _____

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

## FINANCIAL POLICY

Thank you for choosing Cardiovascular Interventions, P.A. as your health care provider. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

- **Co-pays:** The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

- **Insurance Claims:** Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

- **Referrals and Preauthorization's**: Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

- **Self-pay Accounts**: Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

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

- **Missed Appointments:** Cardiovascular Interventions, P.A. requires 24-hour notice of appointment cancellation.

- **Returned Checks:** The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

- **Medical Record Copies:** Patients requesting copies of medical records will be charged: $1 per page plus $1 search fee (if applicable)

- **Minors:** The parent(s) or guardian(s) is responsible for full payment. A signed release to treat may be required for unaccompanied minors.

- **FMLA/ Disability Forms:** A request form must be filled out (Personal Information). There is a $40 fee prior to forms being completed by providers, turnaround time is 7 to 10 business days.

- **Outstanding Balance Policy**: It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection's costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other third party.

**I Agree…**

I agree to pay Cardiovascular Interventions, P.A. Any monies owed it a referral form authorizing the visit is not brought in at the time of the visit.

**The Undersigned…**

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or his/her authorized representative, to release cardiovascular interventions, p.a. Or its employees, from any and all liability which may arise from this action, whether foreseen at present Cardiovascular Interventions, P.A. reserves the right to change and/or modify the information on this site at any time.

**Patient Signature: _____ Date:_____**

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

## ADVANCE CARE PLANNING-PREFERENCE QUESTIONNAIRE (APC)

Please circle the answers that apply to you. Please understand that this questionnaire is being given to all the patients receiving care at Cardiovascular Interventions, PA. It is not being given to you because your doctor is particularly concerned about your health or well-being. Instead, all the patients are receiving this questionnaire, because we believe that everyone should become comfortable with these topics. We hope to open discussions and or circumstances that are often left without preparation for family and caregivers for our patients.

**1) Have you completed any of the following? (Check all that apply to you)**

- ☐ Ordinary will
- ☐ Living will
- ☐ Health care proxy
- ☐ Power of attorney
- ☐ Don't know

**2) During the past 12 months, have you had a discuss ion with any of the following people about your preferences concerning the end of your life? (Check all that apply to you)**

- ☐ Specialist doctor
- ☐ Regular doctor
- ☐ Social worker
- ☐ Nurse or other staff person
- ☐ Family member or my health care proxy
- ☐ Friend
- ☐ Spiritual advisor
- ☐ Some other person
- ☐ I have not discussed these matters during the last 12 months

**3) As you probably know, there are several things doctors can do to try to revive someone, whose heart has s topped beating, which usually includes a machine to help breathing. Thinking of your current condition, what would you want your doctor to do it your heart ever s tops beating? Would you want your doctors to try to revive you, or would you want your doctors not to try to revive you? (Check your choice)**

- ☐ Revive me, including, the use of a breathing machine
- ☐ Allow me to go — do not try to restart my heart or use a breathing machine
- ☐ Don't know

**4) If you had to make a choice at this time, would you prefer a course of treatment that focus es on extending life as much as possible, even if it means having more pain and dis comfort, or would you want a plan of care that focus es on relieving pain and discomfort as much as possible, even if that means not living as long? (Check your choice)**

- ☐ Extend life as much as possible
- ☐ Relieve pain or discomfort as much as possible
- ☐ Don't know

**5) We realize that many people are in excellent health, lead happy and productive lives, and may feel that the above questions are not relevant to their present situation. We would still like to hear your opinion about these matters. Please write here anything that you would like us to know:**

_____

_____

_____