



HeartCare
6310 Health Park Way Suite 120
Lakewood Ranch, FL 34202
(941)-907-8951

New Patient Packet

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Gender: Male/Female

Date of Birth: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

(If you live out of state, please provide additional address)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Information

Phone #: _____ Home/Cell/Work

Phone #: _____ Home/Cell/Work

Email: _____

Permission to receive information on (circle) appointments, testing, labs results, billing information, medical information via: (circle) phone, voicemail, mail.

Emergency Contact:

<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____



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Primary Care Provider: _____ Referring Provider: _____

Preferred Pharmacy

Pharmacy (Local): _____ Phone Number: _____

Pharmacy (Mail): _____ Phone Number: _____

Insurance Information

Primary:

Company: _____ Subscriber: _____

Policy: _____ Group: _____

Secondary:

Company: _____ Subscriber: _____

Policy: _____ Group: _____

Social History

Marital Status: Single/Married/Divorced/Widowed

Number of Biological Children: ____

Tobacco Use: Current/Former/Never

Current: Cigarettes/Cigars/Pipe/Chewing Tobacco

Amount per day: _____

Interested in quitting?: YES/NO

Former: Cigarettes/Cigars/Pipe/Chewing Tobacco

Year Quit: _____ Amount per day: _____

Number of years: _____

Alcohol Use: Current/Former/Never

Number of drinks/week: _____

Employment: Employed/Retired/Disabled

Type of Employment: _____



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Past Medical History

(Circle if you have ever had any of the following health issues)

- | | | |
|--------------------------------|--------------------------|----------------|
| Coronary Artery Disease | Rheumatic Fever | Kidney Disease |
| Coronary Artery Bypass Surgery | Carotid Artery Disease | Acid Reflux |
| Heart Attack | Abnormal EKG | |
| Angioplasty/Coronary Stents | Aneurysm | |
| Pacemaker/Defibrillator | Diabetes | |
| Valvular Heart Disease | High Cholesterol | |
| Arrhythmia | Cardiomyopathy | |
| Obesity | Congestive Heart Failure | |
| Sleep Apnea | Liver Disease | |
| Renal Artery Disease | Arthritis | |
| Stroke | Gout | |
| TIA | Thyroid Disease | |
| Peripheral Vascular Disease | Depression | |
| High Blood Pressure | Anxiety | |
| Bowel Disease | Peptic Ulcer Disease | |
| Anemia | Gall Bladder Disease | |
| Other: _____ | | |

Past Surgical History (Please Include Dates)

_____	_____
_____	_____
_____	_____



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Medication List (continued)

Vein Disorder Questionnaire

1. Do you have swollen ankles or legs? YES/NO
2. Are leg symptoms worse in the evening? YES/NO
3. Do you have Restless Leg Syndrome (RLS)? YES/NO
4. Do you have ropey or bulging varicose veins? YES/NO
5. Any bleeding from spider or varicose veins? YES/NO
6. Sores or ulcers on your legs? YES/NO
7. Thickening and discoloration of the legs or ankles? YES/NO
8. Nighttime cramping? YES/NO
9. Vein related symptoms in your family? YES/NO



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Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by HeartCare for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of HeartCare. I understand my diagnosis or treatment of me by HeartCare may be upon my consent as evidenced by my signature on this document.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of HeartCare.

HeartCare is not required to agree to the restrictions that I may request. However, if HeartCare agrees to a restriction that I request, the restriction is binding on HeartCare.

I have the right to revoke this consent, in writing, at any time, except to the extent that HeartCare has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review HeartCare’s Notice of Privacy Practices prior to signing this document. HeartCare’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of the health care operations of HeartCare. The Notice of Privacy Practices for HeartCare is also provided in our waiting room. The Notice of Privacy Practices also describes my rights and the HeartCare’s duties with respect to my protected health information. HeartCare reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of the Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Description of PR’s Authority



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Assignment of Insurance Benefits

Medical and Supplemental Insurance

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicare Services (CMS) and its agents and/or any supplemental insurance companies any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to HeartCare on my behalf for any services furnished for me or by HeartCare, including physician and midlevel services. I authorize HeartCare to act as my agent and help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, HeartCare may prescribe testing procedures to be performed here. I understand, and have been advised that, according to Florida Law, I am under no obligation to use this facility. **I understand that I am responsible for full payment of any charges, including non covered services, deductibles, and/or copayments due.**

Patient Signature

Date

Printed Name

Commercial Insurance

I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. I request that payment of authorized benefits be made on my behalf to HeartCare for any services provided by HeartCare physicians or midlevel providers. **I understand that I am responsible for full payment of any charges, including non-covered services, deductible and or copayments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. It is my responsibility to ensure that an authorization is on file with HeartCare prior to having my procedure performed. When applicable, I understand that I am responsible for full payment of all charges in the absence of authorization.**

Patient Signature

Date

Printed Name



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Authorization for Release of Health Information

Patient Name: _____ Date of Birth: _____
Social Security Number: _____
Address: _____
Phone Number: _____

I authorize HeartCare to:

() Send my records to: () Obtain my records:

Name of Physician/Facility

Address City State Zip Code

Phone Number Fax Number

For the purpose of () Continued Medical Care () Personal Use () New Patient

Information to be released:

I understand that my records may contain information about alcohol and or drug treatment, mental health or psychiatric treatment and/or HIV/AIDS information. I do hereby expressly and voluntarily consent to the disclosure of my health information as specified, for the purpose or need as indicated above.

I understand HeartCare may utilize a medical record correspondence service and that there may be a fee assess for this service (Please allow 7-10 business days for records to be copied)

I understand this consent will expire 12 months after the date below, or when the information requested with this consent has been released. A photocopy of this authorization shall have the same effect as the original.

Signature of Patient/Legal Representative Relationship to patient Date



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HIPAA Privacy Authorization/Medical Information Release Form

We cannot discuss your health information with anyone other than yourself (including spouse) unless you provide us with authorization to do so. Please list below names of the individual(s) you authorize our office to discuss care with.

*This authorization includes appointment information, complete medical information including treatment plan and/or diagnosis, billing and claim information, and any other pertinent medical information contributed to my health care plan or treatment and care.

I authorize HeartCare to disclose/discuss my protected health information described above with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient

Date of Birth

Printed Name of Patient

Date



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Waiver of Chaperone Form

It is HeartCare LLC policy that, for the protection of the patient and the HeartCare LLC staff, any patient or Provider may request that a second healthcare professional serve as a chaperone during any medical examination. Your rights as a patient include:

- HeartCare LLC should accommodate patient preference as to chaperone gender whenever appropriate and feasible.
- If a chaperone of the requested gender is not available, the Patient shall be given the opportunity to reschedule the appointment within a reasonable amount of time from the originally scheduled date.
- If a patient refuse to have a chaperone for an examination where one is required or one where the Provider has requested a chaperone, HeartCare LLC may transfer care to another provider or clinic.
- The Provider must document the Provider's discussion with the patient regarding HeartCare LLC chaperone requirement and the patient's refusal.
- In a non-emergency situation, the Provider may either perform the examination without a chaperone or refer the patient to another qualified Provider. The Provider must document the referral and the reason for it.

By signing this form, you are waiving the need for a chaperone for office visits, testing and procedures. At any time, a patient may rescind this waiver and request a chaperone. This waiver will remain in place for 1 year from the date of signature and will be renewed on an annual basis. If you have any questions, please don't hesitate to ask the clinical staff or ask to speak to a member of management.

Patient Print: _____ Date: _____

Patient Signature: _____