SOUTH TAMPA
CARDIOLOGY

2919 W. Swann Avenue Suite 105B
Tampa, FL 33609
PH: 813-870-1747 FX: 813-343-6089

# PRIVACY PRACTICE-HIPPA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you 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 shall honor that agreement.

You consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

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**PATIENT INFORMATION**

First Name: ________________________M.I.: _______ Last Name: ________________________________________

Home Address: ________________________________________ City: _______________________ State: ________

Zip Code: _________________ Cell Phone: ______________________ Home Phone: _______________________

Date of Birth: ______________________ Age: ________ Marital Status: Single Married Partnered Divorced Other
(Circle One)

Email: __________________________________________________________ SSN: __________________________

Patients Employer: ________________________________ Occupation: ____________________________________

Work Number: _________________________________ Work Address: ___________________________________

Emergency Contact/Relation: _____________________________________ Phone Number: ____________________

Preferred Pharmacy/Address: ________________________________________________ Phone: _______________

**INSURANCE INFORMATION**

Primary Policy Name: _________________________________ ID Number: _________________________________

Group Number: _____________________________________ Primary Policy Holder: Self Spouse Parent
(Circle One)

Primary Policy Holder's Name: ______________________________ Date of Birth: ____________________________

Secondary Policy Name: _______________________________ ID Number: _________________________________

Group Number: _____________________________________ Secondary Policy Holder: Self Spouse Parent
(Circle One)

Secondary Policy Holder's Name: ______________________________ Date of Birth: __________________________

Tertiary Policy Name: _________________________________ ID Number: _________________________________

Group Number: _____________________________________ Tertiary Policy Holder: Self Spouse Parent
(Circle One)

Tertiary Policy Holder's Name: ______________________________ Date of Birth: ____________________________

**ACKNOWLEGDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE- (HIPPA)**

I acknowledge and agree that I have received a copy of South Tampa Cardiology's Notice of Privacy Practices.

Signature: ________________________________________________ Date: ________________________________

Print Name of Legal Representative: __________________________________ Relationship: ___________________

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**Reason for today's visit? (Why are you here?): _______________________________________________________**

_______________________________________________________________________________________________

## PATIENT HISTORY FORM

**PATIENT CARE TEAM- List all doctors providing care**

| **Doctor's Name** | **Type of Doctor** (Primary Care, Urologist, etc.) | **Phone Number** | **Fax Number** |
|---|---|---|---|
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**ALLERGIES** **Do you have allergies to drugs, food, latex, dye? (circle one) YES NO**

| Allergy- list medication, food, latex, dye (contrast), etc. | Reaction- rash, shortness of breath, hives, itching, etc. | Severity (circle one) |
|---|---|---|
| | | HIGH MODERATE LOW |
| | | HIGH MODERATE LOW |
| | | HIGH MODERATE LOW |
| | | HIGH MODERATE LOW |
| | | HIGH MODERATE LOW |
| | | HIGH MODERATE LOW |
| | | HIGH MODERATE LOW |

**MEDICATIONS** **Please list all prescription medications, over-the-counter medications, and vitamins. (Bring in medication bottles for further clarity)**

| **Medication Name** (full name from bottle) | **Dosage/Strength** (mg, mcg, ml etc.) | **How often do you take it?** (Daily, twice daily, etc.) | **How long have you taken?** (1 month, 2 years, etc.) | **Prescribing Doctor?** |
|---|---|---|---|---|
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**REVIEW OF SYSTEMS** Circle symptoms you are experiencing OR circle "no symptoms"

**General**
- No Symptoms
- Recent Fever
- Chills
- Night Sweats
- Recent weight loss/gain
- Loss of energy

**Integumentary (Skin)**
- No Symptoms
- Rashes
- Changes in hair or nails
- Breast Lumps
- Breast Biopsy

**Eyes**
- No Symptoms
- Blind Spots
- Double Vision
- Recent change in vision

**Hematological**
- No Symptoms
- Excessive bleeding
- Easy bruising

**Psychiatric**
- No Symptoms
- Depression
- Anxiety
- Substance Abuse
- Change in cognitive function

**Respiratory**
- No Symptoms
- Recent Cough
- Wheezing
- Pain when breathing
- Excessive sputum
- Shortness of breath

**Cardiovascular**
- No Symptoms
- Chest pain
- Shortness of Breath
- Leg Swelling
- Heart murmur
- Palpitations

**Abdominal**
- No Symptoms
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain/Cramping
- Blood in stools
- Pain with food

**Genitourinary**
- No Symptoms
- Burning on urination
- Bloody urine
- Difficulty urinating
- Urination at night: #of times _______
- Difficulty with erections

**Musculoskeletal**
- No Symptoms
- Unusual muscle aches
- Arthritis
- Back problems

**Neurological**
- No Symptoms
- Headaches
- Dizziness/off balance
- Stroke
- Weakness
- Numbness

**Ear, Nose, and Throat**
- No Symptoms
- Recent Hearing loss
- Ringing in ears
- Sore throat
- Difficulty swallowing
- Nasal Congestion
- Nose bleeds
- Visual changes

**Endocrine**
- No Symptoms
- Goiter
- Excessive thirst
- Increased Urination
- Unexplained changes in weight

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**PAST MEDICAL HISTORY** Circle your history/diagnoses

**Current/Past Illnesses**

Asthma
Bronchitis/Emphysema/COPD
Cancer: ________________
Diabetes
Kidney stones/kidney failure
Liver/Gallbladder
Peptic Ulcer-GERD
Prostate
Rheumatic Fever
Seizures
Sleep Apnea
Stroke/CVA
Thyroid Disease
Other________________________
______________________________

Infectious Disease History
______________________________
______________________________

Trauma History
______________________________
______________________________

**Current/Past Cardiac Illnesses**

Angina/Chest Pain
Atrial Fibrillation
Congestive Heart Failure (CHF)
Coronary Artery Disease
Heart Attack (MI)
Heart Disease
High Blood Pressure
High Cholesterol
Irregular Heartbeat (Arrhythmias)
Peripheral Vascular Disease
Valvular Heart Disease

**Cardiac Risk Factors**

History of tobacco use
History of Alcohol Abuse
History of Obesity
Sedentary Lifestyle
Age (male over 45/female over 55)
Menopausal Female

**Past Surgeries/Procedures and year done**

Appendectomy ________
Back Surgery ________
Cataract Surgery ________
Gallbladder ________
Hernia-Hiatal/Inguinal ________
Hip Surgery ________
Hysterectomy ________
Intestinal ________
Knee Surgery ________
Prostate Surgery ________
Tonsils/Adenoids ________
Cosmetic Surgery ________
Shoulder Surgery ________
Other ____________________________
__________________________________
__________________________________

**Past Cardiac Surgeries/Procedures and year done**

Cardiac Cath ________
Cardioversion ________
Coronary Angioplasty/Stent ________
Coronary Artery Bypass ________
EP Study ________
ICD ________
Pacemaker Implant ________
RF Ablation ________

**Alcohol Use**

**YES NO** Do you consume alcohol?
Average number per week:
_____ beer _____ wine _____ liquor

**Smoking/Tobacco Use**

**YES NO** Do you smoke or use tobacco?
**YES NO** Have you smoked in the past?
______ Number of years? _____Packs per day?
_______________Year quit?

**Diet**

**YES NO** Are you on a special diet?
What type of diet? ________________
**YES NO** Do you drink caffeinated beverages?
(coffee, tea, cola, etc.)
How many daily? _________________

**Exercise**

**YES NO** Do you exercise on a regular basis?
(Minimum 30 minutes/3 times a week)

**Substance Abuse**

**YES NO** Do you have history of drug dependency?
If yes, specify: ____________________

**Occupation** ____________________________________

____ Retired ____ Unemployed ____ Student

**Residence (patient lives…)(check one)**

____ Alone ____ with children ____with parents
____with spouse ____ with spouse & children
____with male partner ____ with female partner
____ in nursing home ____ in assisted living facility

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**FAMILY HISTORY** (Please check all that apply)

**FATHER**

____ Alive
____ Deceased
At age _______

____ Heart attack before age 60
____Stroke
____Sudden cardiac death
Other History ___________________________________
_____________________________________________
_____________________________________________

**MOTHER**

____ Alive
____ Deceased
At age _______

____ Heart attack before age 60
____Stroke
____Sudden cardiac death
Other History ___________________________________
_____________________________________________
_____________________________________________

**Sibling(s)**

______ **Number of Brother(s)**
#____ Alive
#____ Deceased
At age _______
At age _______
At age _______

____ Heart attack before age 60
____Stroke
____Sudden cardiac death
Other History ___________________________________
_____________________________________________
_____________________________________________

______ **Number of Sister(s)**
#____ Alive
#____ Deceased
At age _______
At age _______
At age _______

____ Heart attack before age 60
____Stroke
____Sudden cardiac death
Other History ___________________________________
_____________________________________________
_____________________________________________

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# South Tampa Cardiology LLC

## AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, to be paid to South Tampa Cardiology, LLC. I authorize the sending of all medical information needed to secure payment. Copies of these records can be mailed, faxed, or transmitted electronically via secure sites. This assignment will remain in effect until revoked in writing. I further permit a copy of this authorization to be used in place of the original.

I fully understand that I am financially responsible for all amounts not otherwise paid by my insurance carrier. (**This includes annual deductibles, co-payments, and charges denied as not covered by my insurance program.)** Account balance are to be paid in full within 30 days of receiving a statement. I understand accounts become delinquent 90 days following date of service and these charges may be assigned to a collection agency.

**Insurance Patients**: Billing your insurance is a courtesy we are happy to provide you. If the insurance does not respond you will become responsible. All co-pays and deductibles are dure in full at time of service. If you are unable to pay your deductible in full, you will need to meet with the billing department to set up a payment plan. If no insurance card is presented upon arrival, you will be considered self-pay.

**Uninsured Patients:** A 15% discount will be offered to you if you pay in full at time of service. Prior to your appointment, arrangements for payment will need to be established.

**Authorizations:** Please call your insurance to obtain insurance requirements for your visit or testing. Failure to obtain necessary pre-authorization or notification may result in a reduction or rejection of benefits by the insurance company.

**Missed appointment fee:** If you miss your appointment, or you cancel with less that 24-hour notice, these may be a $25.00 missed appointment fee charged. Please call us 24hours prior to your appointment to cancel or reschedule.

**Returned Check:** There is a fee (currently $25.00) for any checks returned by the bank.

Confidential information expressly identifies the medical nature of the services rendered. It includes all information and records in the course of treatment. I authorize South Tampa Cardiology, LLC to send copies of my records to my referring physician, primary care doctor, or other medical care providers for treatment purposes. Copies o these records can be mailed, faxed, or transmitted electronically via secure sites.

**I HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND HAVE RECEIVED A COPY UPON MY REQUEST. I ACCEPT RESPONSIBILITY OF ITS TERMS.**

Printed Name: ____________________________________________ Relationship: ____________________________

Signature: _______________________________________________ Date: __________________________________

***If someone other that the patient is signing the authorization, please state the relationship to the patient and the reason why the patient is unable to sign.***

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# Records Release Authorization

Date: ______________________

Requesting Records from Dr(s): ____________________________

________________________________________________________

Type of Records Needed: __________________________________

I hereby authorize you to release my medical records to:

South Tampa Cardiology, LLC
Cesar Alberto Morales-Pabon MD
2919 W. Swann Avenue, Suite 105B
Tampa, FL 33609
Phone: 813-870-1747
Fax: 813-343-6089

Printed Name: _______________________________________

Date of Birth: ________________________________

Signature: _________________________________________

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# Family Authorization Form

In compliance with HIPPA regulations, *South Tampa Cardiology* want to protect your privacy health information. Please list below the names of the people that you authorize our staff and providers to talk to about your health and medical information.

| **Name** | **Relationship** | **Phone Number** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

______________________________ ______________________________

Patient Signature Date