HEART CARE CENTERS
OF FLORIDA

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: Last _____ **First** _____ **M** ____

Mailing Address: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone:** _____

E-mail Address: _____

Marital Status: **(Circle One)** Single Married Divorced Widow(er)

SS#: _____ **Date of Birth**: _____**Age**: _____ **Sex: (Circle One)** Male / Female

Race: _____ **Primary Language**: _____ **Will you need an interpreter? (Circle One)** Yes / No

Primary Care Physician: _____ **Referred By**: _____

Employer's Name: _____ Employer Phone #: _____

Spouse's Name: _____ Date of Birth: _____

Emergency Contact: _____**Relationship**: _____ **Ph#**: _____

List below, to whom this office may speak with regarding your medical care and treatment

1. **Name and phone #** _____
2. **Name and phone #** _____

Insurance Policy Holder Information:

Policy Holder Name: _____ **Phone #** _____ **SS#** _____

Secondary Policy Holder _____ **Phone #** _____ **SS#** _____

Do you have an Advance Directive? (Circle One) Yes No. If YES, What type? Living Will, Do Not Resuscitate, Assignment of Healthcare, Power of Attorney, Assignment of Surrogate. **** This facility does not acknowledge advance directives and if an adverse event occurs during your treatment at this facility, we will initiate resuscitative and stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Healthcare Power of Attorney.****

I authorize Heart Care Centers of Florida and staff to release Protected Health Information to individuals listed above. I grant permission to the employees of Heart Care Centers of Florida to render care to myself and expedite the orders of the physician(s). I further authorize release of this information to other healthcare provider's associated with my care.

Patient Signature: _____ **Date:** _____

HEART CARE CENTERS
OF FLORIDA
Authorization to Release Health Information

Patient Name: _____ **SSN**: _____

Date of Birth: _____ **Phone**: _____

Address: _____

Covering the Period of Healthcare from _____ to _____

Please Release Disclosed Information To/From:

Name (or title) and Organization: **Heart Care Centers of Florida**

Address: 3822 S. Washington Ave., Titusville, FL 32780

Phone: 321-636-6914 Fax: 321-636-6916

Please Release Disclosed Information To/From: (FOR OFFICE USE ONLY)

Name (or title) and Organization: _____

Address: _____

Phone: _____ Fax: _____

Information to be disclosed

___ History & Physical ___ Consultation Reports ___ Summary

___ Progress Notes ___ Physician Orders ___ EKG

___ Complete Health ___ Lab and X-Rays ___ Other

If applicable, I also give permission for the following to be disclosed (please initial)

__ Acquired Immunodeficiency Syndrome (AIDS) or infected with Human Immunodeficiency Virus (HIV)
__ Behavioral Health Services/Psychiatric Care
__ Treatment for Alcohol and/or Drug Abuse

This authorization **does not expire**. I understand I have the right to revoke this at any time in writing. I understand that any disclosure of information carries with it potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, then contact the privacy office at the number above.

Patient Signature: _____ **Date**: _____

Witness Signature: _____ **Date:** _____

Consent to Treat – Acknowledgement of Benefits

CONSENT FOR MEDICAL TREATMENT

I/We voluntarily consent to medical treatment and diagnostic procedures provided by **HEART CARE CENTERS OF FLORIDA** and its associated physicians, clinicians and other personnel. I/We consent to the testing for infectious diseases such as, but not limited to AIDS, Hepatitis and drug testing if deemed advisable by the physician. I/We am/are aware that the practice of medicine and surgery is not an exact science and I/We acknowledge that no guarantees have been made as to the result of treatments or examinations.

ASSIGNMENT OF INSURANCE BENEFITS

I/We guarantee payment of all charges made for or on account of the patient and I/We assign our rights to any insurance benefits or other funding to the physician and **HEART CARE CENTERS OF FLORIDA**. I/We understand that I/We am/are responsible for any charges not covered by insurance or other forms of benefit. I/We understand that **HEART CARE CENTERS OF FLORIDA** can obtain my/our credit report for review in collection of this in the event that my/our account is placed with a collection agency or an attorney for collection or collected. I/We shall pay all collections fees and costs, including reasonable attorney fees for Medicare Beneficiaries. I/We have provided all necessary information for proper assignment of Medicare benefits.

"No Show" Policy

As a courtesy to staff and patients, please call the office upon becoming aware of potential conflicts with your scheduled appointment time.

PLEASE PROVIDE AT LEAST 24 HOUR NOTICE OF ANY CANCELLATION OR RESCHEDULING OF APPOINTMENT. This reserves the right to charge a $50.00 administrative fee for any non-emergent cancellation that is not made within 24 hours of your scheduled appointment.

FORMS

There is a $20.00 fee for completion of disability forms, Life Insurance or Workmen's Compensation forms. Payments shall be made at the time of the form being dropped off. Please **allow 10 business days** for forms completion. Forms cannot be completed prior to your office visit or surgery date. We understand the importance of the completion of your forms. Be certain to provide any and all necessary information to insure that your paperwork is properly accurate.

I have read the above Consent to treat and Acknowledgement of Benefits. I have also read Heart Care Centers of Florida "No Show" Policy, and am aware that failure to show for scheduled appointments or to provide at least 24 hours' notice will result in a $50.00 fee.

Print Name_____ Date _____

Patient/Guarantor Signature_____

HEART CARE CENTERS

Of FLORIDA

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from: **HEART CARE CENTERS OF FLORIDA**

By signing below I provide my permission for Heart Care Centers of Florida to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices

(If you did not receive a Privacy Notice, please check with the receptionist)

Patient Signature: _____ **Date**: _____

For Office Staff Only:

If not signed: (good faith effort to obtain acknowledgement of the receipt)

Describe reason individual would not sign _____

Describe your good faith efforts to obtain the individual's signature _____

_____

Heart Care Centers
Of Florida

Please be advised that due to the nature of this office, at any given time, you may be asked to see the Nurse Practitioner or have your appointment rescheduled, should the Physician(s) be called out of the office due to an emergency.

****

Please refrain from wearing any perfumes or colognes in the office due to patients with allergies or respiratory issues.

****

The office requires that you provide us with all previous cardiac records if you have cardiac history so we may better treat you at the time of your appointment. If the office does not receive those records, your appointment may be rescheduled so that those records can be obtained.

_____ _____

Patient Signature **Date**