

CARDIOLOGY CENTER OF ENGLEWOOD

Registration Form

Patient Name: _____ Date of Birth: _____

Sex: ____ Male ____ Female Marital Status: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Out of State Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Mobile Number: _____

How would you like to receive appointment reminders? ____ Home Phone Voice ____ Cell Phone Voice ____ Text

Email: _____

By listing my e-mail address above, I certify that I am allowing CCE to contact me via e-mail for appointment reminders and health related alerts. I understand that I may receive notifications of a health-related alert based on my personal health information; but this information is not shared with any outside parties. If at any time you do not want to receive this information or need to change the e-mail address on file, please contact the office. WE TREAT YOU'R EMAIL WITH HIPPA STANDARDS – IT IS NOT SHARED AND IS NOT FOR SALE.

Race: _____ Preferred Language (If other than English): _____

Ethnicity: ____ Non-Hispanic ____ Hispanic ____ Other: _____

Name of Current Primary Care Physician: _____ Phone # _____

Who referred you? Name: _____ Phone # _____

Emergency Contact Name: _____ Phone # _____

Relation to Patient: _____

Authorization and Agreement – I hereby authorize my insurance benefits to be paid directly to Cardiology Center of Englewood. I acknowledge that I am responsible to pay non-covered services, benefits paid directly to me and services which are not paid by my insurance in a timely manner. I hereby authorize the release of my medical records to my insurance carrier, other treating physicians, and my attorney in response to subpoena duces tecum or to my representative.

Patient Signature: _____ Date: _____

Legal Guardian/POA: _____ Date: _____

5 pages

CARDIOLOGY CENTER OF ENGLEWOOD

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(941) 475-5621 * Fax (941) 474-8587

Authorization for Release of Health Information

Patient Name: _____ DOB: _____ SS #: _____ - _____ - _____

Patient Address: _____ City: _____ Zip: _____

Telephone#: _____ Cell #: _____

Official Use Only – Do Not Write in This Space

Date request received _____ Medical record #: _____

I authorize the Cardiology Center of Englewood to _____ SEND my records to _____ Obtain my records from _____

Name of Physician or Facility

Telephone # and / or Fax #

City

State

Zip Code

For the purpose of: _____ Continued Medical Care: _____ Personal Use _____ New Patient Appt. on _____

LIST SPECIFICALLY THE INFORMATION TO BE RELEASED:

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

I understand that the Cardiology Center of Englewood may utilize a medical record correspondence service and that there may be a fee assessed for this service.

I understand that the consent will expire in (12) months after the date shown below, or when the information requested with this consent has been released.

A photocopy of the authorization shall have the same effect as the original.

Signature of Patient or Legal Representative

Relationship to Patient

Date



Authorization for Use / Disclosure of Protected Health Information (PHI)

Patient Name: _____ DOB: _____

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called PHI, Protected Health Information, under a federal health privacy law, as described below.

I, authorize CCE, to release and obtain my private health information to/from (check all that applies):

☐ My Spouse/partner: _____

☐ My Primary Care Physician/staff Name of Physician: _____

☐ My Pharmacy Name of Pharmacy: _____

☐ My Parent(s) Name(s): _____

☐ My Child(ren) Name(s): _____

☐ My POA/Healthcare Surrogate Name: _____

☐ None of the above

Are there any restrictions on PHI to be disclosed? ☐ Yes ☐ No

If yes, please describe:

Please print
names if
applicable

The PHI will be disclosed to confirm appointments, to render to caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with CCE. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Privacy Officer at, 601 Medical Drive, Englewood, FL 34223. I understand that my revocation will not affect any actions taken by CCE prior to receiving my revocation. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use of disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective for 1 year from the date signed, at which time this authorization to obtain and release this protected health information expires.

Patient Signature or Authorized Representative

Date

Patient Name Printed

Notice of Privacy Practices

I acknowledge that I was provided with a copy of (or the opportunity to review) the CCE Notice of Privacy Practices.

Patient / Personal Representative Print Name

Signature

CARDIOLOGY CENTER OF ENGLEWOOD

Assignment of Benefits & Financial Policy

ASSIGNMENT OF BENEFITS:

If you have no insurance: I agree to pay my medical expenses, in full, when I am seen by the doctor. If for any reason there is a balance owed on my account, I agree to pay promptly upon receipt of the monthly statement.

If you have Medicare: I request that payment of authorized Medicare Benefits, be made on my behalf to the rendering physician for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines to be my responsibility.

If you have HMO, PPO, or commercial insurance: I authorize any holder of medical information about me to release to my insurance company or its agents any information (including HIV, Alcohol, and mental health) needed to determine benefits payable to related services. I agree to comply with the terms of my Insurance coverage, including payment of my co-payment at the time of service rendered and payment of any portion of charges that my insurance carrier determine to be my responsibility, upon receipt of my monthly statement. I am also responsible for ensuring any referrals required by my insurance to be current for the upcoming appointment including updated primary care provider information as necessary.

If you have Medigap Insurance (Medicare Supplement): I request that payment of authorized Medigap benefits, be made either to me or on my behalf to the rendering physician for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my Medigap carrier any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services.

STATEMENT OF FINANCIAL RESPONSIBILITY

All insurance forms processed by this office, prior to payment in full, are assigned to this practice. Your cooperation in complying with the terms of this assignment will be appreciated. If your visit is related to an auto accident or work-related injury, this Information must be provided prior to seeing the physician and all claims and billing information must be furnished prior to the appointment. Patients who cancel an appointment without a 24-hour notice may be subject to an administrative fee depending upon the length of the scheduled appointments (this fee also applies to diagnostic testing.) Please note that any returned checks will carry an additional \$25.00 fee. I, the UNDERSIGNED, have read the above and realize that all medical charges incurred by me, or my dependents, are my financial responsibility. All court fees, attorney fees, or other fees necessary to collect this account, should it become delinquent, are payable by me.

Patient Signature or Authorized Representative

Date

Patient Name Printed

Patient General Consent to Treatment

I, hereby consent to the administration and performance of general treatments including retrieval and review of medication history, use of prescribed medication, performance of medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of my physician or there assigned designees. I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend that this consent is continuing in nature even after the specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. A photocopy of this consent shall be considered as valid as the original. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

Legal Guardian/POA: _____ Relationship: _____

Peripheral Vascular Disease Questionnaire

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Peripheral Vascular Disease (PVD) is a common circulation problem in which the blood vessels, which carry blood to the legs and/or arms, become narrowed or clogged. Please fill out this questionnaire to help us identify if you have symptoms of Peripheral Vascular Disease.

Circle Yes or No to the following questions:

- | | | |
|---|-----|----|
| 1. Do you have Claudication (dull, cramping pain in hips, thighs or calf muscle) ? | Yes | No |
| 2. Do you experience leg pain when walking? | Yes | No |
| 3. Do you experience leg pain while at rest? | Yes | No |
| 4. Do you have buttock pain? | Yes | No |
| 5. Do you have impotence? | Yes | No |
| 6. Do you have numbness and tingling in the arms, lower legs, feet or toes? | Yes | No |
| 7. Are your fingers or toes pale, discolored, bluish or reddish? | Yes | No |
| 8. Are your hands or feet cold to the touch? | Yes | No |
| 9. Do you have open sores or ulcers on your legs or feet that won't heal? | Yes | No |
| 10. Have you had any previous surgeries and or angioplasty on the arteries in your
Legs, arms or neck? | Yes | No |
| 11. Have you ever been diagnosed with Abdominal Aortic Aneurysm (AAA)? | Yes | No |
| 12. Have you ever been diagnosed with Carotid Artery Disease? | Yes | No |
| 13. Have you ever been diagnosed with Renal Artery Stenosis? | Yes | No |
| 14. Do you have swelling in your legs? | Yes | No |