FLORIDA HEART
ASSOCIATES

Welcome to our Practice!

Dear New Patient:

Welcome and thank you for selecting Florida Heart Associates, P.L. to provide your cardiovascular care. We appreciate the confidence and trust you have placed in us and we will serve you with the very best of care.

It is important to understand that optimum care requires the effort of both you and your professional staff. We will do our part to diagnose, treat and care for you in a friendly and considerate manner. It is your responsibility to listen to your physician, follow his/her instructions, communicate with the practice, keep your appointments and pay for the services you receive.

The business of health care can be complicated sometimes and we will do everything we can to make the experience with our practice a positive one. We are providing several documents for you to read, sign and return when you arrive for your appointment. The *Insurance Assignment and Financial Policies* explain your personal responsibility for account balance payment, as well as insurance co-payments, deductibles, co-insurance, in-network and out-of-network services. The *Patient Demographics and New Patient History* forms assist us to establish personal medical information relevant to your medical care.

You may receive telephone calls to remind you of your appointment and ask questions about your medical history. Please cooperate with the practice by providing the information requested and keep your scheduled appointments. If you find that you will not be able to keep an appointment, please call our office to reschedule at least 24 hours before the appointment time.

We will do our very best to exceed your expectations during each and every visit. Everyone here at Florida Heart Associates, P.L. wants you to receive the very best care and return to a healthy lifestyle.

Sincerely,

Florida Heart Associates, P.L.

FLORIDA HEART ASSOCIATES

NEW PATIENT HISTORY

Date_____

NAME _____ **PHONE** _____

ADDRESS _____

SEX M ____ **F** ____ **DOB** _____ **AGE** _____

ALLERGIES _____

REASON FOR VISIT _____

REFERRED BY _____

PRESENT COMPLAINTS (Please check "Yes" or "No")

YES	NO		
☐	☐	**CHEST DISCOMFORT**	**HOW LONG?** _____
☐	☐	**SHORTNESS OF BREATH**	**HOW LONG?** _____
☐	☐	**ANKLE SWELLING**	**HOW LONG?** _____
☐	☐	**PALPITATIONS**	**HOW LONG?** _____
☐	☐	**LIGHTHEADEDNESS/FAINTING**	**HOW LONG?** _____
☐	☐	**LEG CRAMPS WITH WALKING**	**HOW LONG?** _____
☐	☐	**RECENT ER VISIT**	**WHERE/WHEN/WHY?** _____
☐	☐	**RECENT HOSPITALIZATION**	**WHERE/WHEN/WHY?** _____

HAVE YOU HAD HEART TESTING DONE ANYWHERE ELSE? (ECHO, STRESS TEST ETC.)
IF SO, WHERE and WHEN? NOTE: PLEASE BRING COPIES

****

MEDICATIONS INCLUDING VITAMINS, HERBALS

NAME/DOSE/HOW OFTEN ?_____ _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICAL HISTORY

YES NO

- ☐ ☐ HIGH BLOOD PRESSURE HOW LONG?___
- ☐ ☐ HEART ATTACK WHEN?_____
- ☐ ☐ FAMILY HISTORY/HEART PROBLEMS
- ☐ ☐ PREVIOUS HEART DISEASE/ PROBLEM? _____ WHAT TYPE?_____
- ☐ ☐ HEART CATHETERIZATION WHEN? _____
- ☐ ☐ HEART FAILURE WHEN?_____
- ☐ ☐ IRREGULAR PULSE
- ☐ ☐ HEART MURMUR
- ☐ ☐ NOSE BLEEDS
- ☐ ☐ STROKE
- ☐ ☐ HIGH CHOLESTEROL
- ☐ ☐ DIABETES
- ☐ ☐ THYROID PROBLEMS
- ☐ ☐ LUNG PROBLEMS
- ☐ ☐ GASTROINTESTINAL PROBLEMS
- ☐ ☐ HEPATITIS
- ☐ ☐ RHEUMATIC FEVER
- ☐ ☐ ANEMIA
- ☐ ☐ SCARLET FEVER
- ☐ ☐ ARTHRITIS
- ☐ ☐ SEIZURES
- ☐ ☐ DRUG USE TYPE: _____

PAST MEDICAL HISTORY

ILLNESSES: _____

_____

_____

_____

OPERATIONS: _____

_____

_____

_____

_____

_____

SOCIAL HISTORY

OCCUPATION: _____

DO YOU EXERCISE:_____ TYPE:

TOBACCO USE: ☐ YES ☐ NO ☐ PAST

TYPE: ☐ CIGS ☐ CIGARS ☐ CHEW

AMOUNT: _____ HOW LONG? ____

CAFFEINE USE: YES, #/DAY _____ NO___

ALCOHOL USE: ☐ YES ☐ NO ☐ PAST

DRINKS DAILY ___ WEEKLY__MO___

TYPE_____

****

FAMILY HISTORY

FATHER: AGE _____ DECEASED AT AGE _____REASON_____

HISTORY OF: HEART DISEASE _____ HIGH BLOOD PRESSURE _____ DIABETES _____

VASCULAR DISEASE _____ OTHER _____

MOTHER: AGE _____ DECEASED AT AGE _____ REASON _____

HISTORY OF: HEART DISEASE _____ HIGH BLOOD PRESSURE _____ DIABETES _____

VASCULAR DISEASE _____ OTHER _____

BROTHERS: NUMBER _____ LIVING _____ DECEASED _____

DECEASED AT AGE(S) _____ REASONS _____

HISTORY OF: HEART DISEASE _____ HIGH BLOOD PRESSURE _____ DIABETES _____

VASCULAR DISEASE _____ OTHER _____

SISTERS: NUMBER _____ LIVING _____ DECEASED _____

DECEASED AT AGE(S) _____ REASONS _____

HISTORY OF: HEART DISEASE _____ HIGH BLOOD PRESSURE _____ DIABETES _____

VASCULAR DISEASE _____ OTHER _____

PREVIOUS CARDIOLOGIST

DOCTOR:_____PHONE:_____FAX:_____

ADDRESS:_____

WHAT RECENT TESTING HAVE YOU HAD DONE ?_____

ARE YOU A SEASONAL RESIDENT? _____

IF YOU ARE A SEASONAL RESIDENT:

PLEASE SIGN A "RELEASE OF INFORMATION" FORM AT YOUR DOCTOR'S OFFICE BEFORE YOU LEAVE DIRECTING YOUR PHYSICIAN TO SEND FHA COPIES OF YOUR RECORDS TO KEEP ON FILE WHILE YOU ARE IN FLORIDA.

IS THERE ANY OTHER INFORMATION THAT YOU THINK YOUR DOCTOR SHOULD KNOW?

FLORIDA HEART ASSOCIATES

PATIENT DEMOGRAPHIC PROFILE

PATIENT ACCOUNT# _____

PATIENT'S NAME (Please Print)_____ SEX: M F AGE _____
BIRTHDATE _____ SSN _____MARITAL STATUS: S M W D SEP
LOCAL ADDRESS: _____TELEPHONE #:( ) ____- _____
CITY:_____, FL. ZIP CODE _____
EMPLOYER: _____ WORK TELEPHONE # ( ) _____ - _____
SPOUSE'S NAME _____ BIRTHDATE _____ SSN# _____
SPOUSE'S EMPLOYER _____ _____SPOUSE'S WORK TEL # _____
E-MAIL_____ RACE_____ PRIMARY LANGUAGE _____

Part Time Residents Mailing Address
STREET_____
CITY: _____ STATE _____ ZIP CODE _____

Who referred you to our office? Family/friend_____ Doctor_____ Other_____
Reason for your referral: _____

(HMO Patient) Who is your local primary care doctor? _____

IN CASE OF EMERGENCY, PLEASE CALL: _____

RELATIONSHIP: _____ TELEPHONE # _____

Florida Heart Associates, P.L., participates in the provider networks of Medicare, and many major health plans. You are personally responsible for all co-payments, co-insurance and deductibles as defined by your plan coverage. These fees and charges for "non-covered" services are due and payable at the time of your appointment. Medicare enrollees may be required to sign an "ABN" (Advanced Beneficiary Notice) Form if applicable.

PRIMARY INSURANCE _____
POLICY HOLDER _____ ID # _____
SECONDARY INSURANCE _____
POLICY HOLDER _____ ID # _____

LIFETIME PRIMARY INSURANCE AND MEDICARE "B" SIGNATURE AUTHORIZATION

I HEREBY AUTHORIZE ANY HOLDER OF MEDICAL, OR OTHER PERTINENT INFORMATION ABOUT ME, TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, CENTERS FOR MEDICARE AND MEDICAID SERVICES, OR ITS INTERMEDIARIES OR CARRIERS, OTHER GOVERNMENT SPONSORED PROGRAMS, PRIVATE INSURANCE COMPANIES, OR THE BILLING AGENT OF FLORIDA HEART ASSOCIATES, ANY INFORMATION THAT IS REQUIRED FOR THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS BE ASSIGNED TO FLORIDA HEART ASSOCIATES, P.L.

MANAGED CARE AND HMO PATIENTS

I UNDERSTAND THAT PREAUTHORIZATION APPROVAL FOR EACH APPOINTMENT AND/OR PROCEDURE PRIOR TO A SCHEDULED APPOINTMENT MAY BE REQUIRED. WITHOUT PRIOR AUTHORIZATION, MY INSURANCE COMPANY MAY REFUSE PAYMENT OF CLAIM(S) AND I WILL BE PERSONALLY RESPONSIBLE FOR PART, OR ALL OF, THE INCURRED BILL.

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

Rev 1/22/2015PE

239-938-2000 * Fax 239-278-0404 * www.flaheart.com

1550 Barkley Circle
Fort Myers, FL 33907

1002 Country Club Blvd
Cape Coral, FL 33990

FINANCIAL POLICY

Thank you for choosing Florida Heart Associates, P.L. as your cardiology providers. We are committed to the success of your treatment and care. Please understand that payment of your account is part of this process. The following is our financial policy. Please read this information and let us know immediately if you have any questions regarding the information. Thank you

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED:

At the time services are rendered, we will collect your co-payment or co-insurance, as well as any balance due from a previous date of service. We accept cash, checks, credit cards, as well as Debit cards. We also offer the convenience of making your balance payment online at www.flaheart.com .

We accept Medicare assignment. We also participate with specific commercial insurance plans, Medicare "Replacement" plans and networks. Please ask our office if we participate with your insurance provider. We make every effort to comply with the terms and conditions of the plans with which we do business. However, it is solely your personal responsibility to determine whether your insurance company participates with Florida Heart Associates, P.L., or with any laboratory, radiology, hospital or other facility at which medical services may be scheduled on your behalf. Florida Heart Associates, P.L. assumes no financial responsibility for charges related to services rendered at non-participating facilities.

INSURANCE CLAIMS:

As a courtesy to you, if Florida Heart Associates, P.L. is a participating provider with your insurance plan, we will file your insurance claim for you. Your insurance company makes the final determination regarding your eligibility and benefits. You agree to pay any portion of the charges that are not covered by your insurance company. If we are not participating with your insurance plan, we may file the initial claim but, if payment is not received in 45 days, we will transfer the unpaid balance to you and require you to pre-pay for any future services before they are rendered.

RETURNED CHECKS:

We charge a $25 fee all returned checks.

PAST DUE BALANCES:

We will take the necessary steps to collect "past due" balances. If we need to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If your account is referred for legal action, you agree to pay all of the legal fees that we incur plus court costs. In the event of litigation, you agree the venue shall be in Lee County, Florida. You understand that if your account is submitted to an attorney, collection agency, litigated in court, or "past due" status is reported to a credit reporting agency, the fact that you received treatment at Florida Heart Associates, P.L. will become a matter in the public record.

WORKERS' COMPENSATION/PERSONAL INJURY/AUTO ACCIDENT:

We DO NOT file elective, non-emergent, claims to worker' compensation, personal injury attorneys, or automobile insurance companies. Hospital claims will be filed as required under Florida state law. Unpaid balances remain the responsibility of the patient.

APPOINTMENTS:

We understand that unexpected circumstances can sometimes interfere with your scheduled appointment; however, you are responsible for contacting the office to cancel your scheduled appointment at least 24 hours before the scheduled service to avoid a late cancellation fee added to your account.

I have read and understand the financial policy of Florida Heart Associates, P. L. physicians. I agree to abide by the terms and conditions contained herein.

Patient's Name: _____ Date: _____

Patient's (Guardian's) Signature: _____ Date: _____

1550 Barkley Circle, Fort Myers, FL 33907 1002 Country Club Blvd, Cape Coral, FL

239-938-2000 FAX: 239-278-0404

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Florida Heart Associates revised Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the revised Notice of our Privacy Practices.

_____ _____

Patient Name (Print) Date

_____

Signature

****

CONSENT TO DISCLOSE MEDICAL HEALTH INFORMATION

I specifically authorize the employees of Florida Heart Associates to disclose my protected health information as described on this form to the recipients listed below. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization.

I understand and authorize my health care provider to use an automated telephone and/or e-mail system to use my name, address and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s) for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine. In addition, I authorize my healthcare provider to use a telephone message service to relay this information as well as protected health information necessary to respond to my immediate health issues.

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information:

_____ _____

Name Phone

_____ _____

Name Phone

_____ _____

Patient Signature Date

_____

Patient Name (Print)