FLORIDA HEART ASSOCIATES

Welcome to Our Practice!

Dear New Patient,

Welcome and thank you for selecting Florida Heart Associates, P.L. We appreciate the confidence and trust you have placed in us.

It is important to understand that delivering care requires the effort of both you and our 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 received.

We are providing several documents for you to read, sign and return. We bill your insurance as a convenience to you and having accurate up-to-date information is necessary and required to provide the care you seek. We bill your insurance as a convenience to you, thus the insurance assignment and financial policies explain your personal responsibility for payment, including but not limited to co-payments, deductibles, 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. Should you have questions regarding your account, we provide financial counselors to assist in answering your questions. Please feel free to speak to a financial counselor when you call or arrive for your appointment.

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 your appointment, please call our office to reschedule at least 24 hours before the appointment time.

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.

Please Fill Out The Following Forms & Return within 1 week via:

1. **Email:** **medicalrecords@flaheart.com**
2. **FAX #:** **239-278-0404**
3. **MAIL:** *Florida Heart Associates*
   ATTN: Medical Records 1550 Barkley Circle
   Fort Myers, FL 33907

FLORIDA HEART ASSOCIATES

FHA NEW PATIENT HISTORY

Name _____ **Phone #**_____

Address: _____

DOB: _____ **Allergies:**_____

Reason for Referral: _____ **Referred by:**_____

PRESENT CONCERNS: **Pls circle.**

YES	**NO**	**Chest Pain**	**How Long?** _____
YES	**NO**	**Difficulty Breathing**	**How Long?** _____
YES	**NO**	**Palpitations**	**How Long?** _____
YES	**NO**	**Fainting/Lightheadedness**	**How Long?** _____
YES	**NO**	**Swelling in Legs**	**How Long?** _____
YES	**NO**	**Cramps/fatigue in Legs while Walking**	**How Long?** _____

MEDICATIONS:

DRUG NAME	DOSAGE	ONCE A DAY / TWICE A DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19		

FLORIDA HEART ASSOCIATES

PAST MEDICAL HISTORY:

YES NO High Blood Pressure

YES NO Diabetes

YES NO High Cholesterol

YES NO Thyroid Disease

YES NO Bleeding Issues

YES NO Valve repair or replacement

YES NO Atrial fibrillation (AFib)

YES NO Peripheral artery disease

YES NO Stroke

YES NO Coronary artery disease/heart attack/Stents/Bypass

YES NO Kidney Disease

YES NO Rheumatic Fever

SOCIAL HISTORY:

Currently smoker: _____

Packs per day: _____

Years smoked: _____

Past Smoker: _____

Never Smoked: _____

Vap: _____

Alcohol Use: _____

Caffeine Use: _____

Exercise: YES NO

FAMILY CARDIAC HISTORY:

	Relation:	*Approximate Age Diagnosed*
Heart attack/stents/Bypass		
Atrial Fibrillation (AFib)		
Died suddenly without known cause		
Aneurysm (Brain, Aortic, Coronary)		

CARDIAC SURGERIES: ***(This includes bypass, stents, ablations, valve replacement- mechanical or tissue, valve repair)***

	When?	Hospital? City?
1.		
2.		
3.		

FLORIDA HEART ASSOCIATES

CARDIAC IMAGING	***WHEN:***	***WHERE:***
Last Stress Test	_____	_____
Last Echocardiogram	_____	_____
Cardiac Catherization	_____	_____
Ablation	_____	_____
Last Coronary calcium Score	_____	_____
Last Coronary Cat SCAN	_____	_____
Cardioversion	_____	_____
Holter or ECAT monitor	_____	_____

Recent CARDIAC Hospitalization: WHEN: _____ WHERE: _____

Previous Cardiologist Name: _____

City and State of Previous Cardiologist: _____

Phone#: _____ FAX#_____

Is there any other information that you think your doctor should know?

We thank you for taking the time to fill out this patient package. We look forward to seeing you in our practice!

FLORIDA HEART ASSOCIATES

PATIENT DEMOGRAPHIC PROFILE

Patient Account# (Done by the Office) _____

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 PERONALLY 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

FLORIDA HEART ASSOCIATES

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 financialpolicy. 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:

In the event that payment is not made within 90 days of the first statement date, the Guarantor understands that the account may be referred to an outside collection agency. The Guarantor agrees to reimburse Creditor for the original debt, as well as any and all associated Collection Agency Fees, up to a maximum of 25%, and reasonable attorney's fees associated with collection efforts.

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 (Print):_____ Date:_____

Patient's Signature:_____ Date:_____

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

FLORIDA HEART ASSOCIATES

Authorization for Release of Medical Record Information

I hereby authorize Florida Heart Associates (FHA) to obtain my protected health information, by requesting a copy of my medical records including office notes, labs, imaging, procedures pertaining to my health condition from my Primary Care Physician, Previous Cardiologist or Other Specialist as listed below.

PCP: _____ **Previous Cardiologist**:_____

Other Specialist/Doctor: _____

As described in the notice of privacy practices of Florida heart Associates, PL, I understand that I may revoke this authorization in writing at any time, except to the extent that the action have been taking as outlined by this authorization; the revocation must be in writing and sent to Florida Heart Associates, 1550 Barkley Cir., Fort Myers, FL 33907.

Patient Name: _____ Date of Birth: _____

Patient's Signature: _____ Today's Date: _____

********** **FHA STAFF TO FILL OUT BELOW**********

FHA Staff Requests the Release of Medical Records within the last 5 years requested:

__ All Catherization __ Most recent Echocardiogram ___ Most recent Stress test

__ Most recent Labs/ INR/Lipids __ Last Office Note ___Heart Surgery or Vascular Surgery

__ Most recent Vascular Imaging ___ Most recent MUGA ___ Most Recent Pacer Check

__ Most recent Event or Holter Monitor ___ Most recent EKG ___ Other: _____

Please send the following information to FHA via:

1. EMAIL: **medicalrecords@flaheart.com**
2. FAX: **239-278-0404**
3. MAIL: **Florida Heart Associates, PL**
   Attn: FHA Abstraction
   1550 Barkley Circle
   Fort Myers, FL 33907

FLORIDA HEART ASSOCIATES

Name of FHA Staff Requesting Information: _____ Date: _____

LIVING WILL

Medicare and Private insurance companies require us to participate in different quality programs. One of these requirements is to ask our patients if they have an advanced directive/living will for healthcare. This often includes a patient advocate to express your wishes when you are unable

Patient name: _____ DOB:_____

_____ YES, I have a living will that explains my desires regarding medical treatment in circumstances when I am no longer able to express informed consent. *Please bring a copy to your next appt.*

_____ NO, I do not have one and I do not want any more information

_____ NO, but I would like more information on where to get one.

Living Will/Advanced Directive resources

1. **Department of Elder Affairs:**

   For information on living wills or advance directive, please contact the Department of Elder Affairs helpline at * 850) 414-2000. They can refer you to your county resource.

2. **Florida Senior Legal Helpline: 888-895-7873 (some income restrictions apply)**

HIPAA Notice of Privacy Practices

Revised 2023

Effective as of April/14/2003
Revised January/1/2023

Florida Heart Associates
1550 Barkley Circle
Fort Myers, FL 33907
(239) 938-2000

1002 Country Club Blvd.
Cape Coral FL 33990

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure thatthe physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt outof those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer, 1550 Barkley Circle, Fort Myers, FL 33907. All complaints must be in writing. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient's Name (Print) Date

_____

Patient's Signature

CONSENT TO DISCLOSE MEDICAL HEALTH INFORMATION

I hereby 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 to 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 schedule 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 to 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 Relationship Phone

_____ _____ _____

Name Relationship Phone

_____ _____

Patient's Name (Print) Date

_____

Patient's Signature