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| **PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PATIENT INFORMATION** |
| Patient’s last name: First: MI: | ❑ Mr.❑ Mrs. | ❑Miss❑ Ms. | Marital status (please circle one):Single / Married / Div / Sep / Widow |
| Is this your legal name? | Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (Former name): | Birth date: / /  | Age: | Sex:❑M ❑ F |
| ❑ Yes | ❑ No |
| Mailing address: | Social Security no.: | Home phone no.:( ) |
| City: | State: | ZIP Code: | Cell phone no.:( ) |
| **Do you have a Primary Care Physician or has a doctor referred you to us? If so, who? :** |
| Occupation / Job Title:❑*Retired* | Employer: | Employer Phone no.:( ) |
| **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Preferred Phone**: \_\_\_\_\_\_ CELL \_\_\_\_\_\_\_\_\_\_\_\_TEXT \_\_\_\_\_\_\_\_HOME |
|  |  |  |  |  |  |
| **INSURANCE INFORMATION** |
| ***(Please give your insurance card(s) to the receptionist.)*** |
| Person responsible for bill: | Birth date: / / | Address (if different than patient): | Phone no:( ) |
| To the best of your knowledge, is this person a patient here? ❑ Yes ❑ No |
| Occupation of person holding insurance: | Employer: | Employer phone no:( ) |
| Is the patient covered by insurance? ❑ Yes ❑ No |
| Please indicate **PRIMARY** insurance: |
| Subscriber’s name: | Subscriber’s SSN: | Birth date: / / | Policy/ID/Member #: | Group no.: |
| Patient’s relationship to subscriber: ❑Self ❑Spouse ❑Child ❑Other  |
| Please indicate **SECONDARY** insurance: |
| Subscriber’s name: | Subscriber’s SSN: | Birth date: / / | Policy/ID/Member #: | Group no.: |
|   |  |  |  |  |
| **IN CASE OF EMERGENCY** |
| Name of local friend, relative or caregiver: | Relationship to patient: | Home phone no:( ) | Work phone no:( ) |
| *The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician.* *I understand that I am financially responsible for any balance. I also authorize Heart & Rhythm Associates or insurance company to release any information required to process my claims.*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient/Guardian signature Date |

|  |  |
| --- | --- |
| **IF YOU HAVE A HISTORY OF ANY OF THE FOLLOWING ITEMS, PLEASE INDICATE WHICH APPLY TO YOU BY MARKING THE APPROPRIATE BOX WITH A “CHECK” MARK.****\*\*Do you have a pacemaker or defibrillator? \_\_\_\_\_\_\_\_\_\_ Implant Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****YOUR PAST MEDICAL HISTORY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_****YOUR PAST SURGICAL HISTORY**TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**HOSPITALIZATIONS (REASON/YEAR):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**GENERAL ALLERGIES** BEES ENVIRONMENTAL FOOD LATEX METALS LOCAL ANESTHETHICS TAPE X-RAY DYES I ***IVP DYE/IODONE***MEDICATIONS YOU ARE ALLERGIC TO (PLEASE LIST): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO KNOWN DRUG ALLERGIES | **FAMILY MEDICAL HISTORY**GRANDPARENTS:MATERNAL GRANDFATHER ALIVE DECEASEDMATERNAL GRANDMOTHER ALIVE DECEASEDPATERNAL GRANDFATHER ALIVE DECEASEDPATERNAL GRANDMOTHER ALIVE DECEASEDPARENTS:FATHER ALIVE DECEASED HEART DISEASEMOTHER ALIVE DECEASED HEART DISEASESIBLINGS:SISTERS #\_\_\_\_\_\_ #\_\_\_\_\_ALIVE #\_\_\_\_\_ DECEASEDBROTHERS #\_\_\_\_\_\_ #\_\_\_\_\_ALIVE #\_\_\_\_\_ DECEASED**Any family history of sudden cardiac death**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Please Circle which describes your alcohol consumption best:*** DO YOU DRINK ALCOHOL? YES NOOCCASIONALLY SOCIALLY REGULARLY SMALL AMOUNT MODERATE AMT HEAVY AMOUNTDO YOU EXERCISE: INFREQUENTLY FREQUENTLY SPORTS RELATED NEVER**PERSONAL SOCIAL HISTORY**DO YOU SMOKE? YES NOIF YES, APPROX NUMBER OF CIGARETTES PER DAY? \_\_\_\_\_\_PACKS OF CIGARETTES PER DAY? \_\_\_\_\_\_HAVE YOU QUIT SMOKING? IF SO, HOW LONG AGO? \_\_\_\_\_\_\_\_\_\_DO YOU USE ORAL TOBACCO? YES NODO YOU SMOKE CIGARS? YES NODO YOU SMOKE A PIPE? YES NODO YOU SMOKE ELECTRONIC CIGARETTES? YES NO |

**CHECKLIST: Review of Systems**

# General

□ Weight loss or gain □ Fever or chills □ Trouble sleeping

□ Fatigue □ Weakness

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**Skin**

□ Rashes □ Itching □ Color changes

□ Lumps □ Dryness □ Hair and nail changes

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# Head

□ Headache □ Head injury

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**Eyes**

|  |  |  |
| --- | --- | --- |
| □ Vision □ Glasses or contacts □ Pain □ Redness  | □ Blurry or double vision □ Flashing lights □ Specks □ Glaucoma  | □ Cataracts  |

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**Nose**

□ Stuffiness □ Itching □ Nosebleeds

□ Discharge □ Hay fever □ Sinus pain

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# Throat

□ Teeth □ Sore tongue □ Thrush

□ Gums □ Dry mouth □ Non-healing sores

□ Bleeding □ Sore throat □ Last dental exam

□ Dentures □ Hoarseness

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# Neck

□ Lumps □ Pain

□ Swollen glands □ Stiffness

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 **Respiratory**

|  |  |  |
| --- | --- | --- |
| □ Cough (dry or wet, productive) □ Sputum (color and amount)  | □ Coughing up blood (hemoptysis) □ Shortness of breath (dyspnea)  | □ Wheezing □ Painful breathing  |

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**Gastrointestinal-**

□ Swallowing difficulties □ Change in bowel habits □Yellow eyes or skin

□ Heartburn □ Rectal bleeding (jaundice)

□ Change in appetite □ Constipation

□ Nausea □ Diarrhea

# Urinary

□ Frequency □ Blood in urine □ Change in urinary

□ Urgency (hematuria) strength

□ Burning or pain □ Incontinence

# Cardiovascular

|  |  |  |
| --- | --- | --- |
| □ Chest pain or discomfort □ Tightness □ Palpitations □ Shortness of breath with activity (dyspne)  | □ Difficulty breathing lying down (orthopnea) □ Swelling (edema)   | □ Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)  |

□ AFIB (Abnormal Heart Rhythm)

□ High Cholesterol

□ Coronary Artery Disease

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# Vascular

□ Calf pain with walking □ Leg cramping

(Claudication)

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# Musculoskeletal

□ Muscle or joint pain □ Back pain □ Swelling of joints

□ Stiffness □ Redness of joints □ Trauma

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**Neurologic**

□ Dizziness □ Weakness □ Tremor

□ Fainting □ Numbness

□ Seizures □ Tingling

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# Hematologic

□ Ease of bruising □ Ease of bleeding

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# Endocrine

□ Head or cold intolerance □ Frequent urination □ Change in appetite

□ Sweating (polyuria) (polyphagia)

□ Thirst (polydypsia)

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**Psychiatric**

□ Nervousness □ Memory loss □ Stress

□ Depression

**PLEASE READ AND INITIAL EACH STATEMENT**

**PRESCRIPTIONS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_The first step to refilling your prescription is to call your pharmacy and request a refill request to be faxed to our office. Some medications can be electronically transmitted to the pharmacy; other types of medications require that you pick up a written prescription from our office.

Prescription refills take 48 hours to process and complete. Please allow yourself at least two business days to get the medication filled. Please plan if the prescription is due on a weekend or holiday and give us enough time to prepare the prescription.

Requests for same day walk in refills (requested by walking into the clinic) will not be honored. You must give the staff 24-48 hours to prepare the prescription. A request that is called in or faxed after 3pm will be considered a following day request.

If your prescription runs out early for any reason (for example, you take more than is prescribed or you lose your prescription/medication), your provider will not prescribe extra medication for you or give you and early refill. If you run out of your medication early, you will have to wait until the next prescription is due.

We do not refill prescriptions after hours and on the weekends. There will be no refills after hours by any of our on-call physicians or physician assistants for any reason. The on-call providers are to be called for emergencies only.

**GENERAL CONSENT**

\_\_\_\_\_\_\_\_\_\_ I consent to evaluation and treatment of the condition for which I have come to Heart and Rhythm Associates, PLLC and authorize the physicians and other health care providers affiliated with Heart and Rhythm Associates, PLLC, to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by Heart and Rhythm Associates, PLLC. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Heart and Rhythm Associates, PLLC. I have had an opportunity to discuss it, and any questions I have had have been answered to my complete satisfaction. I also understand that I have the right to refuse any procedure offered.

\_\_\_\_\_\_\_\_\_\_\_I authorize Heart and Rhythm Associates, PLLC to file my medical insurance. I request payment of the authorized insurance benefits, including Medicare (if I am a Medicare beneficiary) be made to the aforementioned provider for any services or equipment provided. A photocopy of this assignment will be considered effective and valid as the original.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_The Notice of Privacy I acknowledge that I have the right to request and receive a copy at any time. This is also posted in our lobby.

\_\_\_\_\_\_\_\_I authorize the release of any medical or demographic information to determine medical benefits or to facilitate payment for such services.

 \_\_\_\_\_\_\_\_I understand that I am financially responsible to Heart and Rhythm Associates, PLLC and the clinic for any charges not covered by my healthcare benefits. It is my responsibility to notify the aforementioned provider of health coverage changes or additions in a timely fashion. I understand that if all or part of the balance is denied by insurance, I am responsible for the balance in full.

 \_\_\_\_\_\_\_\_I understand that payment for services are due in full at the time of service unless other arrangements have been made in advance. At the time of service, I will pay for my co-pay or co-insurance portion and/or deductible.

**FLORIDA MEDICAID**

\_\_\_\_\_\_\_\_I understand Heart and Rhythm Associates, PLLC is NOT a Medicaid Provider. This includes any Medicaid replacement plans.

\_\_\_\_\_\_\_\_I understand I will be financially responsible for any CO Pay, Co-Insurance or deductibles that are accrued.

**LATE POLICY**

If you are running late for your appointment, please contact our office. We will determine whether or not your appointment will need to be rescheduled.

 If you arrive more than 15 minutes late to your scheduled Appointment time, we will make an effort to accommodate you.

However, your appointment may be rescheduled.

**NO SHOW POLICY**

\_\_\_\_\_\_\_\_\_A No Show Fee of $50 will be applied to your account for Missed appointments (including ultrasound testing) or a Cancellation less than 24 hours prior to your appointment.

A No Show Fee of $200.00 will be applied to your account for Missed Appointments for Nuclear Stress Testing as medications is ordered specifically for you.

 If you need to Cancel your appointment, please call 24 hours prior to your appointment to either cancel or reschedule. If you have three (3) or more No Shows in a 12-month period, you may be discharged from our practice.

Last minute cancellations will be evaluated on a case-by-case basis and may be considered a No Show at the Physician’s and/or the Manager’s discretion.

**Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT AUTHORIZATION FORM**

Authorization to Release Information to Family Members.

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize **Heart and Rhythm Associates, PLLC** to release my records and any information requested to the following individuals.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_