CONFIDENTIAL PATIENT INFORMATION

Date: _____
Name: Last
_____Middle_____First_____
Mailing Address
_____
Home Phone: _____Cell Phone: _____ Work Phone:
_____
SS# _____Date of Birth _____ Age _____ Sex: (Circle one) Male / Female
E-mail
address_____
Marital Status: (Circle one) Single Divorced Married Widow(er)
Race _____Primary Language _____ Will you need interpreter? Yes No
Spouse's Name_____Date of Birth
_____SS#_____
Primary Care Physician: _____Referred By:
_____
Emergency Contact:
_____Relationship_____Ph#:_____
Employer Name_____ _____ _
<u>List below, to whom this office may speak with regarding your medical care and treatment-</u>

- **Name and phone#**
  _____
- **Name and phone #**
  _____

Insurance Policy Holder Information:

Policy Holder
Name_____Phone_____SS#_____
Secondary Policy Holder
_____Phone_____SS#_____
Do you have an Advance Directive? (Circle) Yes No. If YES, What type? Living Will, Do not Resuscitate, Assignment of Healthcare, Power of Attorney, Assignment of Surrogate.
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 HCCF to render care to myself and expedite the orders of the physician. 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_____
Address_____
Date of Birth_____Phone _____
Covering the period of healthcare from (dates) _____to_____

Information to be disclosed:
__History and Physical __Consultation Reports __ Summary
__Progress Notes __ Physicians orders __EKG
__ Complete Health __ Labs and X-rays __ Medication records
__Treatment __Care Plan __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

Please release information to HEART CARE CENTERS OF FLORIDA

3822 S. Washington Av
Titusville, Florida 32780
Ph: 321-636-6914
Fax: 321-636-6916

600 Palmetto St., Suite 1
New Smyrna Beach, Fl 32168
Ph: 386-423-3870
Fax: 386-424-3871

I understand that I have the right to revoke this information at any time. This authorization will expire in 90 days. 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 any questions about the disclosure of my health information, then contact the privacy officer at the number above.

Patients Signature_____Date_____

Witness_____Date_____

CONSENT TO TREAT - ACKNOWLEDGMENT 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 collection agency or 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. Payment 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 accurately.

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 appointment or provide at least 24 hours' notice of will result in $50.00 fee.

Patient/Guarantor
Signature_____Date_____

Print
Name_____
_

Heart Care Centers of Florida
PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of a receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgment, 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 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 Privacy Notice, please check with receptionist.)
For office Staff:
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*_____

Patient
Signature:______________________________________Date_______________________________