ALL ITEMS MUST BE COMPLETED. PLEASE PRESENT YOUR INSURANCE CARDS TO THE FRONT DESK

LAST NAME	FIRST NAME	GENDER: MALE FEMALE	BIRTHDATE / /	AGE
MARITAL STATUS S M WID DIV SEP	SOC. SECURITY #	HOME TELEPHONE	CELL PHONE #	
MAILING ADDRESS		CITY	STATE	ZIP
HOME "RESIDING" ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)		CITY	STATE	ZIP
EMPLOYER;			EMPOLOYER PHONE #	
EMAIL ADDRESS	EMERGENCY NAME AND PHONE NUMBER OF FRIEND OR RELATIVE:			
ARE YOU 'ACTIVE" MILITARY YES NO	TO COMPLY WITH FEDERAL REGUULATIONS, WE ARE REQUIRED TO ASK YOU TO FILL OUT THE FOLLOWING: RACE: ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKAN ☐ ASIAN ☐ NAT'L HAWAIIAN/PACIFIC ISLANDER ☐ ETHNICITY: HISPANIC OR LATINO? ☐YES ☐ NO ☐ PREFER NOT TO DISCLOSE			

1) PRIMARY INSURANCE COMPANY NAME		INSURANCE POLICY ID #	
INSURANCE GROUP #	NAME OF SUBSCRIBER	SUBSCRIBER'S BIRTH DATE	RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DAUGHTER SON
2) SECOND INSURANCE COMPANY NAME		INSURANCE POLICY ID #	
INSURANCE GROUP #	NAME OF SUBSCRIBER	SUBSCRIBER'S BIRTH DATE	RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DAUGHTER SON

PRIMARY CARE PHYSICIAN:	**PHYSICIAN TEL #:**
REFERRING PHYSICIAN:	**PHYSICIAN TEL #:**
I HEREBY GRANT PERMISSION TO COMPLETE CARDIOLOGY CARE TO ACCESS MY FULL MEDICATION HISTORY: ☐ YES ☐ NO	

LOCAL PHARMACY:	**ADDRESS:**	**PHONE:**

I ACKNOWLEDGE RECEIPT, REVIEW AND AGREEMENT OF THE FOLLOWING DOCUMENTS: 1) PATIENT FINANCIAL FORM, 2) NOTICE OF PRIVACY PRACTICES.

I HEREBY GIVE MY CONSENT FOR COMPLETE CARDIOLOGY CARE TO RELEASE PHI ABOUT ME TO THE FOLLOWING PERSON(S); (PLEASE SPECIFY THE RELATIONSHIP, E.G., SPOUSE, IMMEDIASTE FAMILY, CAREGIVER, ETC):

1)_____ **2)** _____

3)_____ **4)** _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

REFERRING DOCTOR:	**PHARMACY NAME & PHONE #:**

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

Cardiac History	□ Catheterization □ Angioplasty/Stents □ Bypass Surgery □ Heart Attack □ High Blood Pressure □ Low Blood Pressure □ Valve Replacement □ Pacemaker or Defibrillator □ Ablation □ History of Atrial Fibrillation
	□ Diabetes □ High Cholesterol □ Renal Disease □ COPD □ Asthma □ Leg cramps when walking □ Heart palpitations or flutter
	□ Chest Pain □ Sharp □ Fullness □ Heaviness ~ How long does it last? What relieves it?
	□ Shortness of breath with chest pain □ Burping with chest pain □ Dizzy spells □ Passed out ~ When?

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	□ Sedentary (No exercise)					
	□ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	□ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	□ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Caffeine	□ None	□ Coffee___c/day	□ Tea___c/day	□ Cola___c/day		
Alcohol	Do you drink alcohol?				□ Yes	□ No
	If yes, what kind?		How many drinks per week?			
Tobacco	Do you use tobacco?				□ Yes	□ No
	□ Cigarettes ____ pks./day		□ Chew ___/day	□ Pipe___/day	□ Cigars___/day	
	#of years____	Year quit_____				
Vape	Do you Vape?	□ Yes □ No				
Drugs	Do you currently use recreational or street drugs? (Marijuana, etc.)				□ Yes	□ No
	Have you ever given yourself street drugs with a needle?				□ Yes	□ No
Personal Safety	Do you live alone?				□ Yes	□ No
	Do you have frequent falls?				□ Yes	□ No
	Do you have vision loss?				□ Yes	□ No
	Do you have hearing loss?				□ Yes	□ No
	Do you have an Advance Directive or Living Will?				□ Yes	□ No

FAMILY HEALTH HISTORY

	AGE	HEALTH PROBLEMS		AGE	HEALTH PROBLEMS
FATHER CIRCLE: **ALIVE OR DECEASED**			***Children***	□ M □ F	
MOTHER CIRCLE: **ALIVE OR DECEASED**				□ M □ F	
Sibling INDICATE: **ALIVE OR DECEASED**	□ M □ F			□ M □ F	
	□ M □ F			□ M □ F	
	□ M □ F		**G'MOTHER** *Maternal*		
	□ M □ F		**G'FATHER** *Maternal*		
	□ M □ F		**G'MOTHER** *Paternal*		
	□ M □ F		**G'FATHER** *Paternal*		

MEDICATIONS		
PLEASE LIST ALL CURRENT MEDICATIONS, DOSES, AND FREQUENCIES		

PATIENT CONSENT FOR RELEASE AND USE OF PROTECTED HEALTH INFORMATION

I, _____ ,hereby give my consent to Complete Cardiology Care to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record. Our practice originates and maintains paper and/or electronic health records describing my health history, symptoms, examination and test results, diagnoses, treatment, including HIV/AIDS, mental health or substance abuse and any plans for future care or treatment.

I understand that if I do not sign this form, Complete Cardiology Care may refuse to treat or care for me.

I understand that I have a right to review the practices Notice of Privacy Practices (the "Notice") for a more complete description of the uses and disclosures prior to signing the consent. The Notice provides detailed information about how we may use and disclose your confidential information.

I understand that Complete Cardiology Care has reserved the right to change the privacy practices that are described in this Notice. I also understand that if Complete Cardiology Care makes changes in this notice, their office will provide me a copy of the revised Notice in accordance with the procedures set forth in the Notice itself.
I understand that I have the right to request that Complete Cardiology Care restrict how my health information is used or disclosed, but that Complete Cardiology Care is not required to agree to my request. However, if Complete Cardiology Care does agree to my request, the restriction will be binding on Complete Cardiology Care. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by sending written notice of my desire to do so to Complete Cardiology Care. I also understand that if I revoke this consent such revocation will not be effective to the extent that Complete Cardiology Care has already relied on it to use or disclose my health information.

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

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

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.
As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.
Effective Date of this Notice Under HIPAA regulations in effect on 4/14/03 rev 2/12/15
Contact Person: M. Albone
Phone Number: 386-672-1023 Press extension for Billing

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains.
Acknowledgement of Notice of Privacy Practices
"I hereby acknowledge that I have received a copy of this practices ***NOTICE OF PRIVACY PRACTICES*** , I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified or changed in any way."

Signature:_____ Date:_____

Patient refused to sign _____

Patient was unable to sign because:_____

COMPLETE CARDIOLOGY CARE FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, copayments and deductibles for participating insurance companies. Complete Cardiology Care accepts cash, personal checks, VISA, and MasterCard and Discover. There is a service charge for returned checks.
Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. lf you need assistance or have questions, please contact **The Billing Office between 9:00 a.m. and 3:00 p.m., Monday through Friday at 386-449-7829.**

REFUNDS

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received.

MANAGED CARE

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from your Primary Care Physician. We will request the referral but that is not a guarantee your physician will authorize your visit.

Signature:_____ Date:_____

APPOINTMENT AND PROCEDURE CANCELLATION POLICY

For Office Appointments

A cancellation made with **less than a 24 hour** notice significantly limits our ability to make the appointment available for another patient in need. Therefore, Complete Cardiology Care has instituted an appointment cancellation policy.

Patients are required to provide our office a 24-hour notice in the event that you need to cancel or reschedule your appointment. This will allow us the opportunity to provide care to another patient. Appointment cancellations must be left with the office **NOT THE ON CALL SERVICE.**

1. The "No-Show", "No-Call" or missed appointment without proper 24-hour notification may be assessed a **$40 fee**.
2. This fee is not billable to your insurance
3. If you are 20 minutes or more late to your appointment, the appointment may be cancelled and rescheduled. The applicable fee may be assessed.
4. **As a courtesy**, we make reminder calls for appointments two days in advance. Please note, if a reminder call or message is not received, the cancellation/no-show policy remains in effect.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

APPOINTMENT AND PROCEDURE CANCELLATION POLICY – CONT.

For Procedures

A cancellation made with **less than a 72 hour** notice significantly limits our ability to schedule a procedure for another patient in need. Therefore, Complete Cardiology Care has instituted a procedure cancellation policy.

Patients are required to provide our office a 72-hour notice in the event that you need to cancel or reschedule your procedure. This will allow us the opportunity to provide care to another patient. Appointment cancellations must be left with the office **NOT THE ON CALL SERVICE.**

1. The "No-Show", "No-Call" or missed procedure without proper 72-hour notification may be assessed a **$100 fee**.
2. This fee is not billable to your insurance

I have read and understand the Procedure Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the release of any and all information, including the diagnosis, and the records of any treatment and examination rendered to me.

RECORDS TO BE RELEASED FROM:

Physician/Facility: _____

Address:_____

City/State/Zip:_____

Phone: Fax:_____

RECORDS TO BE SENT TO:

Physician/Facility: Complete Cardiology Care, P.A.

Address: 305 Memorial Medical Parkway, Suite 300

City/State/Zip: Daytona Beach, FL 32117

Phone: 386.672.1023

Fax: 386.263.2996

PATIENT INFORMATION:

Patient Name:_____

Date of Birth:_____

Date:_____

Signature of Patient: _____

Witness Signature: _____