



DATE _____

PATIENT INFORMATION

Name _____	Birth Date _____	
Address _____	SS# _____	
City, State _____	Zip _____	Male () Female ()
Home # _____	Cell # _____	
Email _____	Marital Status (circle) M D S W	
Preferred Language: () English () Spanish		
Race: <input type="checkbox"/> White <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other _____		
Primary Doctor _____	Employer _____	
Did another Physician refer you? Yes ___ No ___ If yes, Physician _____		

INSURANCE INFORMATION

Insurance Name _____	
ID# _____	Group# _____
Policy Holder Name _____	Birth Date _____
Relationship: Self () Spouse () Other () _____	
Policy Holder Address _____	City, State, Zip _____

EMERGENCY CONTACT AND PHARMACY

Emergency Contact _____	
Relationship _____	Phone _____
Pharmacy _____	Phone _____
Address _____	City _____
How did you hear about us? _____	



History and Physical

Patient Name _____ **Date** _____

Reason for visit _____

Medical History

List your past illnesses/injuries and date of occurrence:

Injury/Illness	Date	Injury/Illness	Date
_____	_____	_____	_____
_____	_____	_____	_____

List any surgeries you have had:

Surgery	Date	Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

List any medication allergies you have and your reaction to them: _____

Please list all medications that you take, both prescription and non-prescription:

Medication/Dose:

_____	_____
_____	_____
_____	_____
_____	_____

Advanced Directives:

- I have Advanced Directives/Living Will.
 - I do not have Advanced Directives/Living Will.
- I authorize a copy of this form to be valid as the original.

I hereby give authorization to the physicians of Cardiac Care Group, LLC to review my medication history as prescribed by other physicians.

Print Name

Signature



Welcome to Our Office!

We welcome you to our office and appreciate the opportunity to provide you with medical services. We strive to provide the highest quality healthcare to our patients with compassion and integrity.

Fees and Payments

We make every effort to keep down the cost of your medical care. It is our policy to ask for payment at the time of your visit. For your convenience, we accept Visa, MasterCard, American Express and Discover. As a convenience to all our patients, we also offer an on-line payment option through our website at www.FLCCG.com. You can use this method with a credit or debit card to process payments for any co-pay, co-insurance, deductibles or balances not covered by your insurance.

Insurance

Your insurance contract is an agreement between you and your insurance carrier. We participate with most major insurance carriers. As required by most insurance carriers, you are responsible for the payment of deductibles, co-payments, co-insurance and any non-covered services at the time of your office visits. It is your responsibility to get an authorization or referral from your insurance company or primary care physician if that is required or you will be charged the full amount on the day of the visit.

HMO/POS Insurance:	You must have a current HMO card and a referral sheet from your Primary Care Physician and pay your applicable co-pay, co-insurance or deductible. If you do not have any referral, your visit may be rescheduled or you may be financially responsible for the entire amount. Your applicable co-pay, co-insurance or deductible is due at the time of service.
PPO Insurance:	You must have a current PPO card. Your applicable co-pay, co-insurance or deductible is due at the time of service.
Medicare Insurance:	You must have a current Medicare card, and be prepared to pay your deductible and/or 20% of the allowed charges, if you do not carry a secondary medical insurance.
Private Insurance:	We expect you to pay your deductible and/or 20% at the time the services are rendered. We will file a claim with your insurance carrier.
No Insurance/Self Pay:	We ask for payment in full at the time of service.
Current Insurance:	If the insurance information you give us at the time of your visit is not correct, you will be held responsible for payment.

Signature

Date

Print Name



Assignment of Insurance Benefits

I assign payment directly to Cardiac Care Group, LLC the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment. I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.

Medicare Patients

I certify that the information given by me in applying for payment under Title XVIII if the Social Security Act is correct. I authorize Cardiac Care Group, LLC to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or related Medicare claim. I hereby authorize payment directly to Cardiac Care Group, LLC for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to, routine testing may not be covered by Medicare unless the physician provides medical necessity.

Billing

We will furnish you with a monthly statement of your account showing the amounts billed to you and any payments received on your account. This monthly billing will also provide you with a detailed aging of how long balances have been outstanding.

Collection Policy

Payments for services which have been billed to you are due in full within 30 days of receipt of your billing statement. If you fail to pay within a reasonable amount of time or cooperate with the terms of an agreed upon payment schedule your account may be turned over to an outside agency for resolution.

Any and all fees that are incurred by Cardiac Care Group, LLC associated with the collection of your account will be charged to your account and are your responsibility.

Credit Policy

In cases of hardship we may agree to set up a payment schedule for patient balances due. All payment plans are arranged on a case by case basis. Please speak with a Manager or billing representative if payment arrangements are necessary.

I acknowledge and agree I am responsible for payment of all co-pays, deductibles, and co-insurance under my insurance policy, plan, or program.

I acknowledge that some services may not be covered by my insurance. If my insurer does not authorize or cover a service or treatment and I nevertheless decide to receive such service or treatment, I agree that I am responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements, including any advance beneficiary notice (ABN), which may be applicable under Medicare.

Signature

Date

Print Name



Protected Health Information (PHI) Disclosure Authorization

I have received/been offered a copy of the Cardiac Care Group, LLC Notice of Privacy Practices. I understand that Cardiac Care Group, LLC (CCG) may use or disclose my protected health information (PHI) for the purpose of medical treatment, payment and healthcare operations. CCG may also share information in the following circumstances:

- During a medical emergency, if the restricted information is needed to provide emergency care
- For certain public health activities
- For reporting abuse, neglect, domestic violence or other crimes
- For health oversight activities, law enforcement investigations, judicial or administrative proceedings
- For identifying decedents to the coroner, or determining cause of death
- For worker’s compensation programs
- For uses or disclosures otherwise required by law.

To respect your privacy, CCG may leave detailed messages at the following **telephone numbers**:

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA): The patient’s medical records may not be furnished to and the medical condition of the patient may not be discussed with any other person than the patient, the patient’s legal representative, or other health care practitioners involved in the care and treatment of the patient without the patient’s written authorization. The patient may at this time authorize an individual to be actively involved in the patient’s information as mentioned below. Until revoked in writing or until this authorization expires, CCG may disclose information in the patient’s medical records to the following individuals:

Name	Relationship
_____	_____
_____	_____
_____	_____

Authorization for Release of Confidential Information: I hereby authorize Cardiac Care Group, LLC to release medical information contained in my/the patient’s records to any insurance carrier, employer or other third party intermediary utilized by the patient for the purpose of obtaining information and/or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of records may also be sent to referring physicians’ offices directly or through Interoperability and Health Information Exchanges for continuity of care. Medical records released may include any diagnostic or therapeutic information of visits and/or procedures performed in the office.

Opt out of Interoperability and Health Information Exchanges ()

Unless indicated below the records may include any confidential information regarding HIV/AIDS and sexually transmitted diseases, alcohol or drug treatment, and mental health treatment.

By initialing below, I direct that the following shall not be included in any disclosures, except with my subsequent authorization or to the extent required or permitted by applicable law without my authorization:

- HIV/AIDS and sexually transmitted information – Initial here to not include this information ____
- Alcohol or drug treatment information – Initial here to not include this information ____
- Mental health treatment information – Initial here to not include this information ____

I understand that I can revoke this authorization at any time by written request to CCG and that it is otherwise valid for one year. I understand that CCG may not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.

Patient Signature: _____ **Date:** _____

Print Name: _____ **Birth Date:** _____

Witness: _____ **Date:** _____



AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize _____ to disclose the following protected health information to:

**CARDIAC CARE GROUP, LLC
South Cape Business Center
3208 Chiquita Blvd. S, Suite 110
Cape Coral, FL 33914
Tel: 239.574.8463
Fax: 239.574.8491**

Please Fax the Records

All of my medical records are authorized and directed to be released to CCG including, without limitation, copies of any medical, psychiatric and other mental health-related matters, HIV, AIDS and AIDS-related syndromes, HIV Testing, alcohol and/or substance abuse related information.

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Cardiac Care Group, LLC, for the purpose of continuity of care.

This authorization shall be in force and effect until _____
Valid for 1 year from date signed if a date is not entered

at which time this authorization to use or disclose this protected health information expire. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Office Manager of Cardiac Care Group, LLC, at 3208 Chiquita Blvd. S, Suite 110, Cape Coral, FL 33914. I understand that a revocation is not effective to the extent that Cardiac Care Group, LLC has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to additional disclosure by the recipient and may no longer be protected by federal or state law. Cardiac Care Group, LLC, will not condition my treatment, payment, enrollment, (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to refuse to sign this authorization.

Signature

Date of Birth

Print

Date

Social Security #

Signature of Witness

Communication/Reminder Consent Form

SMS Reminders and Notifications

I consent to the practice contacting me by text message for the purpose of health promotion, practice news, appointment reminders, and to advise me of Doctors running behind schedule and any follow-ups if required.

I acknowledge that appointment reminders and follow- up reminders by text are an additional service and that they may not be sent on all occasions and that the responsibility for attending appointments, cancelling them and calling for results still rests with me. I understand I can cancel the text message facility at any time.

Text messages are generated using a secure facility and I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified e.g. only first names will be used.

Email

I consent to the practice contacting me by email for the purpose of health promotion, practice news and general follow-ups for preventative care.

Emails are generated using a secure facility but I understand that they are transmitted over the internet and as such may not be secure. However the practice will not transmit any information which would enable an individual patient to be identified. I understand I can cancel the email facility at any time.

I understand that any SMS and email I forward to the practice are transmitted over public phone networks and the internet and may be intercepted and not reach the practice.

Personal Information

This information will be scanned into your health record. Personal information retained in your file is stored in a secure data area and treated as highly confidential.

Name	
Date of Birth	
Mobile Phone Number	
Email Address	

I have read the above information regarding the Email and SMS Reminders/Notifications and agree to the terms and conditions listed. I give permission to be contacted by:

SMS Email (Data and messaging charges may apply)

I decline to receive notifications in this format.

Signature: _____

Date: _____

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:
-------------------	--------------

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Cardiac Care Group, LLC

Cardiac Screening

Patient Name _____

Date _____

Date of Birth _____

Primary Insurance _____

Is this a Medicare Replacement Plan? Yes () No ()

ASSAY –

Current Medication: Inadequate Results ____ Adverse Drug Reactions (ADR) ____

Beta Blockers:

Atenolol __ Bisoprolol__ Carvedilol__ Coreg__ Inderal__ Lopressor __

Metoprolol__ Nadolol__ Nebivolol__ Pindolol__ Propanolol__ Sotalol__

Timolol__ Toprol__ Other _____

Statin:

Lovastatin__ Pravachol(Pravastatin)__ Crestor(Rosuvastatin)__ Lipitor(Atorvastatin)__

Vytorin(Simvastatin)__ Zocor(Simvastatin)__ Other _____

Anti Coagulant:

Warfarin__ Pradaxa__ Eliquis__ Xarelto__ Plavix__ Effient__ Aspirin__ Other _____

CVP – Cardiovascular Profiler

Do you have numbness in the legs? Yes () No () with () without () activity

Do you have tingling in the legs? Yes () No () with () without () activity

Do you have pain in the legs? Yes () No () with () without () activity

Skin Dryness () Flaking () Cracks or Ulcers () Thinning ()

Callus () Infection () Bruising () Hair loss ()

I73.9 (PVD) I70.211 R I70.212 L I70.213 B

CMT – Cardio-Metabolic Risk

Do you have Diabetes? Yes () No ()

E11.49 (DM+Neuro) E13.43 (DM/Auto) E13.49 (DM/Neuro Comp)

Have you had any of the following?

Numbness () Tingling () Fatigue () Burning pain () Sharp/Jabbing ()

or electric-like pain () in feet__ or hands__ Loss of sweating () Excessive sweating ()

G90.09 G60.8 G60.9

Lack of coordination () Dizziness () Lightheadedness ()

R55 (Sync) I95.1 (OH)

Office Use Only

ASSAY_____

CVP_____

CMT_____