# Cardiac Care Group, LLC

## PATIENT INFORMATION SHEET

ACCT.# _____ TODAY'S DATE _____

### PATIENT INFORMATION

Name_____ Male( ) Female( ) Birth Date _____

Address _____ SS# _____

City_____ State_____ Zip _____

Home Phone _____ email _____

Work Phone _____ Marital Status (circle) M D S W

Referred By: _____ Employer: _____

Preferred Language: _____ Are you of Hispanic or Latino origin? Y N

Race, please check one: □ White □ Black or African-American □ Hispanic □ American Indian/Alaska Native

### PRIMARY INSURANCE INFORMATION

Insurance Company Name_____ Phone# _____

Address _____ HMO____PPO____POS____Commercial____

ID# _____Policy# _____Co Pay_____ Deductible_____ Coverage %_____

Policy Holder Name_____ Relationship to Guarantor (circle) Self Spouse Child Other

Policy Holder Address _____ City, State, Zip _____

Home Phone _____ Birth date _____ SS# _____

Employer _____ Employer's Address _____

### SECONDARY INSURANCE INFORMATION

Insurance Company Name_____ Phone# _____

Address _____ HMO____PPO____POS____Commercial____

ID# _____Policy# _____Co Pay_____ Deductible_____ Coverage %_____

Policy Holder Name_____ Relationship to Guarantor (circle) Self Spouse Child Other

Policy Holder Address _____ City, State, Zip _____

Home Phone _____ Birth date _____ SS# _____

### REASON FOR VISIT AND EMERGENCY CONTACT INFORMATION

Consultation _____ Test _____ Hosp F/U _____ Other _____ Appt. with Dr. _____

PCP Name _____ Phone # _____

Emergency Contact: _____ Relationship _____ Phone: _____

Pharmacy preference: _____Location_____ Phone: _____

# Cardiac Care Group, LLC

## Initial History and Physical

Patient Name _____ Date _____

Reason for visit _____

Name of your Primary Care Doctor (PCP) _____

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 |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Social History: Please (X) all that applies to you personally:
( ) Married ( ) Single ( ) Widow(er) ( ) Divorced List your occupation _____

Are you a smoker? ( )Yes ( ) No – If yes, how may daily? _____
If you ever smoked, when did you quit? _____

Do you drink alcohol? ( )Yes ( ) No- If yes, how much? _____

Do you /have you ever used illicit drugs? ( )Yes ( ) No- If yes, what drugs are you/have you used?_____

Do any of your family members have any of the following illnesses? – Please mark (X) all that apply: ( ) Diabetes ( ) Heart Disease ( ) Heart Attack ( ) High Blood Pressure ( ) Stroke ( ) High Cholesterol Levels

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 - How often - Start date | Medication - Dose - How often - Start date |
|---|---|
| 1._____ | 6. _____ |
| 2._____ | 7. _____ |
| 3._____ | 8._____ |
| 4._____ | 9._____ |
| 5._____ | 10._____ |

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

_____ _____

**Print Name** **Signature**

Page 2. Initial History and physical Patient Name _____

REVIEW OF SYSTEMS

Please check (X) all that apply to you personally:

| | |
|---|---|
| CONSTITUTIONAL: | ( ) Weight Loss ( ) Fatigue ( ) Fever |
| RESPIRATORY: | ( ) Cough ( ) Coughing up blood ( ) Wheezing |
| EAR, NOSE & THROAT: | ( ) Difficulty ( ) Ringing in the ears ( ) Vertigo/dizziness |
| | ( ) Sore Throat ( ) Nasal allergies ( ) Hoarseness |
| GASTROINTESTINAL: | ( ) Heartburn ( ) Nausea/Vomiting ( ) Constipation ( ) Diarrhea |
| | ( ) Change in Bowel Movements ( ) Black or Tarry Stools |
| | ( ) Blood in Stools ( ) Jaundice ( ) Abdominal Pain |
| CIRCULATORY: | ( ) Leg Pain while Walking ( ) Foot Ulcers |
| GENITOURNRINARY: | ( ) Pain while Urinating ( ) Burning while Urinating |
| | ( ) Urinary Frequency ( ) Overnight Urinary Frequency |
| | ( ) Difficulty Urinating Females Only: ( ) Abnormal Periods |
| HEMATOLOGIC/LYMPH: | ( ) Bruising Easily ( ) Enlarged Glands ( ) Bleeding Gums |
| | ( ) Bleeding that does not heal or stop quickly |
| MUSCULOSKELETAL: | ( ) Joint Pain or Swelling ( ) Joint Stiffness ( ) Muscle pain |
| | ( ) Back Pain ( ) Neck Pain |
| SKIN: | ( ) Rashes or Sore ( ) Lesions ( ) Itching/Burning Skin |
| NEUROLOGICAL: | ( ) Seizures ( ) Weakness/Paralysis ( ) Numbness |
| | ( ) Tremors ( ) Memory Loss |
| ENDOCRINE: | ( ) Hair Loss ( ) Heat or cold Intolerances |
| | ( ) Brittle or Easily Broken Nails |
| ALLERGIC/IMMUNE: | ( ) Hay Fever ( ) Asthma ( ) Hives/Eczema |
| PSYCHIATRIC: | ( ) Anxiety ( ) Depression ( ) Mood Swings ( ) Insomnia |

_____

Signature of Reviewing Staff Member

# Cardiac Care Group, LLC
## FINANCIAL POLICY

In compliance with the Federal consumer Protection Act, Cardiac Care Group, LLC is furnishing you with information regarding your financial responsibilities.

Welcome! We are pleased you have chosen Cardiac Care Group, LLC for your specialty healthcare needs. We'd like to familiarize you with how our services are billed, which insurance claims we file on your behalf, when we request payment from you and our credit policies. It is our belief that the best service is possible when there is a mutual understanding between you and the physician. We ask that you take the time to read our policy so we can avoid any misunderstandings. If you have any questions our billing department will be happy to discuss them with you.

### Insurance

Cardiac Care Group, LLC participates in many PPO and HMO plans, as well as other commercial insurance products and Medicare/Medicaid. All co-pays are due at the time services are rendered.

If you have an indemnity plan (80/20) and your deductible has been met we will file for you. You will be responsible for you 20% at the time services are rendered. If your deductible has not been met, payment in full is required at time of service.

After 30 days all unpaid balances will be transferred to your responsibility.

Please direct questions to a billing representative.

Note: Even though we may participate in your insurance program, some charges may always be your responsibility. It is always your responsibility to make sure appropriate authorization has been obtained for procedures and/or hospitalizations when necessary. If your insurance company refuses to pay for services due to lack of an authorization you will be responsible for these non-covered charges.

It is always your responsibility to understand that our office cannot accept responsibility for payment or nonpayment on your insurance claims. Questions about coverage and benefits are between you and your insurance company.

For patients not covered under any billable plans, we require payment at time of service.

### 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.

Payment can be made in cash or by check from a local bank. We also accept Master Card, visa and American Express.

### 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.

## 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 you 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.

## Refund Policy

Overpayments to your account will be refunded to you within 30 days of overpayment, provided your account has a credit balance. If there is an outstanding balance due on your account all credits will be applied to that balance prior to issuing a refund.

In order to avoid problems due to delayed mail please notify us of any change in status such as name, address, phone number or insurance coverage.

_____ _____

Date Signature

# Cardiac Care Group, LLC

## AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION

Consent to Treatment: the patient and/or authorized representative does hereby consent to any and all medical treatments which may deem advisable by the physician(s) of Cardiac Care Group, LLC.

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 for continuity of care. Medical records released may include any diagnostic or therapeutic information of visits and/or procedures preformed in the office. Unless initialed below the records may not include and confidential information regarding:

_____ Alcohol/Substance Abuse
_____ Mental Health
_____ HIV

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' information as mentioned above:

_____ _____

Name Relation

List anyone you would like us to release medical information to.

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.

Pre-Authorization: Your insurance company may require pre-authorization for office e visits and/or procedures. I understand that if proper authorization is not obtained from my PCP (primary care physician) I will be liable for charges incurred.

Patient/Guarantor Agreement: I understand that Cardiac Care Group, LLC is not in the business of extending credit. Therefore, it is the policy of Cardiac Care Group, LLC to require payment in full at the time of service. If unable to pay patient due balance in full at the time of service, I agree to make prior arrangements with the Billing Department.

I understand that I am financially responsible for my/the patient's account with Cardiac Care Group, LLC regardless of my insurance benefits.

I authorize a copy of this form to be valid as the original.

Advanced Directives: ☐ I have Advanced Directives/Living Will. ☐ I do not have Advanced Directives/Living Will.

Patient/Responsible Party: _____

Date : _____ Witness: _____

# Cardiac Care Group, LLC

## PATIENT METHOD OF DISCLOSURES

The HIPPA Privacy Rule gives the individual the right to request their confidential communications be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
____ OK to leave message with detailed information
____ Leave message with callback number only

☐ Written Communication
____ OK to mail to my home address
____ OK to mail to my work/office address
____ OK to fax to this number _____

☐ Work Telephone _____
____ OK to leave message with detailed information
____ Leave message with callback number only

☐ Other _____
_____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

PART-TIME RESIDENT:

If part –time resident: name, address and phone number of your out-of-state physician:
Physician:_____ Phone#: _____

Address: _____

**POWER OF ATTORNEY (POA): IF THE PATIENT HAS A COURT DESIGNATED POA REPRESENTATIVE, PLEASE ATTACH A COPY OF THE LEGAL DOCUMENTATION.

Cardiac Care Group, LLC

# 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:

1) _____

2) _____

3) _____

Please list those persons to whom you authorize CCG to release any information to including copies of exams, test results, appointment times & dates, medical & financial information. Only the names listed will be allowed to receive this information. Do **NOT** include your physicians on this list.

| Name | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

What is your mother's first name? _____

By providing this information we can confirm your identity if you assign a designee, who is not listed above, to obtain PHI on your behalf. You should expect a telephone call to obtain authorization for PHI release and your identity will be confirmed with the security question.

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: _____

Guardian/Representative Signature: _____ Date: _____

Relationship to patient: _____

Witness: _____

Date: _____

# Cardiac Care Group, LLC

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize _____

_____

(Please include Dr's full name, address, telephone, and fax number if applicable)

to disclose the following protected health information to:

CARDIAC CARE GROUP, LLC
Louis J. Scala MD, FACC, FASA
South Cape Business Center
3208 Chiquita Blvd. S, Suite 110
Cape Coral, FL 33914
Tel: 239.574.8463
Fax: 239.574.8491

Specifically describe the information to be disclosed, including, but not limited to , meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc…

_____

_____

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 _____

Date or event that relates to the purpose of the disclosure

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 of Patient or Personal Representative | Signature of Witness

_____ _____ _____

Social Security # | Patient Date of Birth | Date

_____ _____

Name of Patient or Personal Representative | Description of Personal Representative Authority

**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.

| I. Signature: | J. Date: |
|---|---|
| | |

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.