Cardiac Care Group, LLC

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: □ White □ African-American □ Hispanic □ Asian □ 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? _____

Cardiac Care Group, LLC

# 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**

Cardiac Care Group, LLC

**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

Cardiac Care Group, LLC

**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 understand that I am financially responsible for my account with Cardiac Care Group, LLC regardless of my insurance benefits.

_____ _____

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:

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

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 you identity will be confirmed with this security question:

What is your mother's first name? _____

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 initialed below the records may not include any confidential information regarding:
(  ) Alcohol/Substance Abuse  (  ) Mental Health  (  ) HIV

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: _____

# 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 advice 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

☐ I decline to receive notifications in this format.

Signature: _____ 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**

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 Date of Birth

_____ _____

Print Date

_____ _____

Social Security # Signature of Witness

**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: |
|---|---|
| | |

# 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__ Asprin__ Other _____

**CVP – Cardiovascular Profilor**

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_____