CARDIOVASCULAR SOLUTIONS INSTITUTE

Patient Registration

Patient Information

First Name:	Middle Initial:	Last Name:	Age:	DOB: / /
SSN: - -	Gender: M / F	Home Phone: Check the box of the Primary Phone Number ☐		
Billing Address:		Work Phone: ☐		
City, State & Zip:		Cell Phone: ☐		
Email:		Race/Ethnicity: Black Hispanic White Other:		
Marital Status: M S D W Other:_____		Primary Language:		
Primary Physician:		Referring Physician:		

Out of State Address

Address:	Phone Number:
City, State & Zip:	

Insurance Information

PRIMARY INSURANCE		Subscriber:	DOB: / /
Address:		Policy ID:	Group:
City, State & Zip:			
Plan Phone #:		Patient Relationship to Subscriber:	
SECONDARY INSURANCE		Subscriber:	DOB: / /
Address:		Policy ID:	Group #:
City, State & Zip:			
Plan Phone #:		Patient Relationship to Subscriber:	

Parent/Legal Guardian/Spouse & Emergency Contact Information

Parent/Legal Guardian/Spouse Name:	Emergency Contact:
Relationship to Patient:	Relationship to Patient:
Home Phone: Other Phone:	Home Phone: Other Phone:

Medical Authorizations & Release of Information

I hereby authorize CardioVascular Solutions Institute to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. I hereby authorize CardioVascular Solutions Institute to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

x_____
Signature

_____
Date

OVER>>

CARDIOVASCULAR SOLUTIONS INSTITUTE

Patient Registration

Payment of Services, Insurance Benefits, Authorization to Release/Obtain Information

I hereby authorize CardioVascular Solutions Institute, A Medical Corporation to obtain any medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any medical records concerning my care to any physician, hospital or other health care professional currently providing care to me. Additionally, I authorize the Practice to release any medical records concerning my care to my medical insurance company (i.e. Medicare, Medicaid, and insurance company, third party administrator, or managed care company) except as specifically provided: _____.

I am aware that the records may contain information relating to psychiatric or psychological testing, physical abuse and/or alcohol abuse and/or HIV test results, if any.

I realize that I am responsible for payment of all medical service rendered to me, regardless of the decision regarding reimbursement made by my insurance carrier. If I am not eligible or services rendered are not covered benefits under the terms of my Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered.

x_____ _____
Signature Date

By **refusing to sign the above, I understand that my insurance company will not be billed by CardioVascular Solututions Institute and I am responsible for payment at the time of service. **

x_____ _____
Signature Date

Authorization to Release Medical Information to Individuals/Family Members

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with the members of your family or other individuals (someone other than yourself or your doctors) that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize the Practice to release verbally and/or photo copies of any or all medical and billing information, pertaining to my medical care, to the following family members or individuals: I understand this information may only be released to the individual after proper identification has been presented to the office. The authorized person may be requested to obtain this information by appearing in person at the office.

☐ I **do not authorize** the Practice to release any or all information concerning my medical care to any individual except as set forth above.

☐ I **authorize** the Practice to release verbally and/or photocopies of any or all information concerning my medical care (appointments, prescriptions, etc) to the following individuals:

_____ _____
Name Phone #

_____ _____
Name Phone #

_____ _____
Name Phone #

x_____ _____
Signature Date

Witness (office use only): _____ Date: _____

CARDIOVASCULAR SOLUTIONS

HEALTH HISTORY

Date:_____

Name:_____ DOB:_____

Referring Doctor:_____ Primary Doctor:_____

Why are you seeing a cardiologist? _____

History and Physical – Please (X)

Heart problems or symptoms:

- ☐ Heart Attack
- ☐ Angina
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Abnormal Rhythm (arrhythmia)
- ☐ Palpitations, irregular heartbeats
- ☐ Fainting
- ☐ Enlarge Heart
- ☐ Chest Pains or Pressure
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Swollen Legs
- ☐ Heart Failure
- ☐ Blue Lips or Fingernails
- ☐ Leg Cramps when you walk

Have you ever had:

- ☐ Stress Test (Treadmill)
- ☐ Echocardiogram
- ☐ Cardiac Catheterization
- ☐ Coronary Angioplasty (balloon)
- ☐ Coronary Bypass Surgery
- ☐ Valve Surgery
- ☐ Electrophysiology Study/Proc.
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ ECG
- ☐ 24 Holter Monitor
- ☐ Event Recorder

Check if you have:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Ever Smoked
- ☐ Diabetes
- ☐ Do you exercise (walking)

Close family member with:

- ☐ Heart Attack
- ☐ Angina

If a Woman have you:

- ☐ Passed Menopause
  if so what age:____
- ☐ Take Estrogen replacement

Please tell us anything else about your heart:_____

_____

Current Medications:

(Include over-the-counter medications)

Name of Medication	Dose	Times per Day

Allergies:

Are you allergic to any medications? ☐ Yes ☐ No

List medications to which you are allergic:_____

What kind of reaction did you have?_____

Past Medical History – Please (X) any symptoms you have or have had in the past year.

Constitutional

- ☐ Lack of energy
- ☐ Trouble sleeping
- ☐ Loss of Appetite
- ☐ Weight changes
- ☐ Fever

HEENT

- ☐ Blurred vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Buzzing or ringing in ears
- ☐ Hay fever
- ☐ Sinus Problem

Respiratory

- ☐ Wheezing
- ☐ Cough
- ☐ Coughing blood
- ☐ Asthma
- ☐ Tuberculosis

OVER >>

HEALTH HISTORY Continued:
Name:_____

Digestive
- ☐ Indigestion
- ☐ Change in bowel habits
- ☐ Bloody or tarry stools
- ☐ Jaundice
- ☐ Liver problems
- ☐ Ulcers
- ☐ Gallstones

Dermatological
- ☐ Rash
- ☐ Itching
- ☐ Other skin problems

Neurological
- ☐ Paralysis (even temporary)
- ☐ Stroke
- ☐ Numbness
- ☐ Loss of balance
- ☐ Dizziness

Hematological
- ☐ Bleeding
- ☐ Easy bruising
- ☐ Risk Factors for HIV
- ☐ Anemia
- ☐ Cancer

Urinary
- ☐ Frequency
- ☐ Infections
- ☐ Stones
- ☐ Bladder incontinence

Men
- ☐ Prostate problems
- ☐ Night-time urination

Women
- ☐ Abnormal Menstrual Periods
- ☐ Could you be pregnant?

Psychiatric
- ☐ Unusual thoughts
- ☐ Nervousness
- ☐ Crying or sadness
- ☐ Depression
- ☐ Suicide attempts

Musculoskeletal
- ☐ Joint pain, swelling or redness
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscle aches
- ☐ Muscle tenderness
- ☐ Gout

Female Reproductive
- ☐ Breast lumps Recent
- ☐ Mammogram
- ☐ Pap Smear &/or Pelvic Exam

Endocrinology
- ☐ Thyroid disorder
- ☐ Diabetes
- ☐ Excess thirst
- ☐ Excess hunger
- ☐ Excess urination

Have you had any operations?

1)_____ 2)_____
3)_____ 4)_____

Are you being treated now or have been treated for any illness?

1)_____ 2)_____
3)_____ 4)_____

Social History:

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

With whom do you live?_____
Occupation_____
Leisure Activities_____
_____
Education Level_____

Health Habits:

Do you smoke? ☐Yes ☐No
How many packs per day?_____
For how many years?_____
How much alcohol do you drink?_____
Do you use any drugs?_____

Family History:

Check if any close family members (parents, brothers and sisters, children) have:

☐ Heart Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child

Are there any other health problems in your family?_____

Hospitalizations:

Year	Hospital	Reason

Acknowledgement of Receipt of Notice of Privacy Practices

CARDIOVASCULAR SOLUTIONS INSTITUTE

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_____ Print Name:_____

Date:_____ Telephone:_____

If not signed by the patient, please indicate relationship:

☐ Parent of guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name & Address of Patient:_____

_____

Notice of Privacy Practices Acknowledgments Tracking Information

For Office Use Only:

Date received:_____ Processed by:_____

Practice Follow-up: Yes☐ No☐ Date of Practice Follow-up:_____

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:_____

Reasons for refusal:_____

CARDIOVASCULAR
SOLUTIONS
INSTITUTE
714 Manatee Avenue East. Suite A • Bradenton, Florida 34208
941.747.8789 • Fax 941.747.8711

Medical Records Release

Name: _____ **SS#:** _____ **Date of Birth:** __/__/__ MM/DD/YYYY

Address _____ **Phone #** _____

CardioVascular Solutions may OBTAIN copies of my records listed below from:

1. (Physician or facility which has health information)
Name: _____
Address: _____
_____
Phone: _____ Fax: _____

2. (Physician or facility which has health information)
Name: _____
Address: _____
_____
Phone _____ Fax: _____

CardioVascular Solutions may RELEASE copies of my records listed below to:

1. (Physician or facility to receive health information)
Name: _____
Address: _____
_____
Phone: _____ Fax: _____

2. (Physician or facility to receive health information)
Name: _____
Address: _____
_____
Phone: _____ Fax: _____

☐Consultation (date) _____
☐Progress note (date) _____
☐Stress echo (date) _____
☐Nuclear Stress (date) _____
☐Event Recorder (date) _____
☐Hospital Reports (date) _____
☐Echocardiogram (date) _____
☐Lab Reports (date) _____
☐Holter (date) _____
☐Cath/PCI (date) _____
☐ECG (date) _____
☐Copy of All Records (up to 7 yrs)
☐Other _____

I AUTHORIZE THE RELEASE OF ALL INFORMATION AND I AM AWARE THAT THE RECORDS RELEASED MAY CONTAIN CONFIDENTIAL INFORMATION RELATING TO PSYCHIATRIC OR PSYCHOLOGICAL TESTING, PHYSICAL ABUSE OR DRUG/ALCOHOL ABUSE.
☐ CHECK HERE TO EXCLUDE CONFIDENTIAL INFORMATION

X_____ _____ _____
Patient's Signature **Date** **Signature of Witness**

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____
Name of Guardian/Representative **Legal Relationship** **Date**

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER DATE SIGNED

THE INFORMATION CONTAINED HEREIN IS PROHIBIITED FOR USE FOR OTHER THAN THE STATED PURPOSE.

CARDIOVASCULAR
SOLUTIONS
INSTITUTE

Gino J. Sedillo, MD, FACC
Stacey B. Royce, PA-C

OFFICE POLICIES

Office Hours - Mon - Thurs 9:00am-5:00pm, Fri 9:00am-3:00pm. The doctor on call after office hours is available only for urgent medical issues. In the event of an emergency, you should call 911 or go to the nearest hospital.

Appointments - Please inform our front desk staff of any change of insurance, phone number, or address. If you are unable to keep your scheduled appointment, please call our office more than 24 hours in advance to reschedule or cancel. If you miss an appointment, and do not call to cancel, you may be dismissed from the practice. If you are more than 15 minutes late for an appointment, you may be asked to reschedule.

Telephone/Online Messages - Non-urgent messages will be returned by the end of the day. If you have an urgent problem, please speak with a nurse (do NOT leave a message). Please allow up to 48 hours to process prescription refill requests. Disability and other insurance forms may take one week for completion.

Medical Records - Medical records will be released to you with a signed request. The charge is $0.25 per page with a maximum charge of $10.00

Financial Policies - Co-pays, coinsurance, and any outstanding balance are due at the **time of service.** Any financial hardship or payment plans must be addressed prior to the appointment. Please make sure any authorizations or referrals required for your visit are obtained prior to your appointment.

Overdue Balances -

By default, patient accounts are *flagged for collections* when **ALL** of the following criteria are met:

- **10** days since the last patient statement was mailed;
- At least **4** statements have been mailed to the patient; and
- The minimum balance is more than **$4.99**.

Updated 11/1/2011

CARDIOVASCULAR SOLUTIONS INSTITUTE, LLC
714 MANATEE AVENUE EAST, SUITE A
BRADENTON, FLORIDA 34208
941-747-8789

Privacy Officer: PRACTICE MANAGER **Effective Date: NOVEMBER 1, 2011**

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.