CARDIOLOGY CONSULTANTS
Of Southwest Florida

Name ____ Date ___________________

Local Address____

City ______________________________State___________ Zip__________________

Home Phone_________________ Cell__________________ Work_________________

Northern Address/ Phone Number____

____

Email ________________________________ Gender: Male Female Transgender

Race/Ethnicity__________________________ Language _______________________

Date of Birth _______________ Marital Status: Single Married Widowed Divorced

Primary Care Physician____

Social Security ________________ Employer Name____________________________

In Case of Emergency: Name ____

Phone Number________________________ Relationship________________________

Primary Insurance________________________ ID#_____________________________

Secondary Insurance______________________ ID#_____________________________

Pharmacy ____________________________ Phone #___________________________

Name of Spouse (Only needed if Insurance is in spouse's name): ______________________________

Spouse's Date of Birth_____________ Spouse's Social Security __________________

How did you hear about our office? ____

Patient Signature________________________________ Date ___________________

CARDIOLOGY CONSULTANTS
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ASSIGNMENT AND RELEASE

The Non-Medicare Patient

I hereby assign to Cardiology Consultants of Southwest Florida any and all benefits from any insurance plans or any other protection maintained by the Patient and/or for the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to Cardiology Consultants of Southwest Florida for services provided to the patient by Cardiology Consultants of Southwest Florida. I certify that the information given by me to Cardiology Consultants of Southwest Florida in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

The Medicare Patient

I request that payment of authorized Medicare benefits be made to me or on my behalf to Cardiology Consultants of Southwest Florida for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to Cardiology Consultants of Southwest Florida in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa, MasterCard, American Express and Discover.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor-in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment or co-insurance at the time of your visit.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand this policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

Patient Name ____ Date ___________________________

Signature _______________________________________ Witness _________________________________

CARDIOLOGY CONSULTANTS
Of Southwest Florida

Notice of Privacy Practices

We are required to provide you with our "Notice of Privacy Practices" upon request. Please notify the receptionist if you would like a copy.

Please provide the information below:

Your Name (please print) ____

Date of Birth ______________________

Do you give permission to discuss your medical and financial information with family members and/or friends?

Yes _______ No ________

If yes, please list the friends/family members that you would like to authorize us to speak to:

Name Relationship Phone Number

- ____
- ____
- ____
- ____
-

The "Notice of Privacy Practices" was made available to me.

Your Signature____ Date __________________

CARDIOLOGY CONSULTANTS
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MEDICAL HISTORY

Name: ______________________________ DOB:__________________

Referring Physician:______________________________

Reason for visit:______________________________

Patient Medical History:

Diabetes no yes
Hypertension no yes
Hyperlipidemia no yes
Cancer no yes
Stroke no yes
Heart Trouble no yes
Arthritis/ Gout no yes
Hepatitis no yes
HIV/AIDS no yes
Varicose Veins no yes
Allergies ______________________
____

Previous Surgeries:

____
____
____
____

Medications/ Dosages:

____
____
____
____
____
____

Patient Social History:

Occupation:______________________ Retired: YES________ NO __________
Alcohol Us: Type ______________________ Frequency______________ Years____________
Tobacco Use: Type____________________ Packs per day________ years______ Quit date_________
Caffeine Use: Type______________________ How many cups per day? ________
Recreational Drug Use: YES NO Type______________________
Exercise: Type _____________________ ____ How many times per week?______________________

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father:	_____	______________________	______________________
Mother:	_____	______________________	______________________
Grandfather			
Maternal:	_____	______________________	______________________
Paternal:	_____	______________________	______________________
Grandmother			
Maternal:	_____	______________________	______________________
Paternal:	_____	______________________	______________________

	How many?	Diseases/If Deceased, Cause of Death
Brothers:	____	______________________
Sisters:	____	______________________
Sons:	____	______________________
Daughters:	____	______________________

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Please Check All That Apply:

Constitution:
- ☐ Weight Gain
- ☐ Loss of Appetite
- ☐ Fever
- ☐ Weakness
- ☐ Weight Loss
- ☐ Night Sweats

Peripheral Vascular:
- ☐ Varicose Veins
- ☐ Spider Veins
- ☐ Leg Pain
- ☐ Leg Swelling
- ☐ Ulceration
- ☐ Heaviness
- ☐ Leg Tiredness
- ☐ Leg Heaviness
- ☐ Restless Legs
- ☐ Itching or Burning

ENT:
- ☐ Cold
- ☐ Cough
- ☐ Coughing Blood
- ☐ Hearing Loss
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ Snoring

Ophthalmology:
- ☐ Diminished Vision
- ☐ Eye Irritation
- ☐ Blurring of Vision
- ☐ Vision Loss
- ☐ Wear Contacts
- ☐ Wear Glasses

Endocrinology:
- ☐ Fatigue
- ☐ Excessive Sweating
- ☐ Weight Loss
- ☐ Sleep Disturbance
- ☐ Cold Intolerance
- ☐ Hives

Cardiology:
- ☐ Chest Pain
  - ☐ Substernal
  - ☐ With Exertion
  - ☐ At Rest
  - ☐ Radiating to Back/Arm/Jaw
  - ☐ Relieved with Nitroglycerin
- ☐ Palpitations
- ☐ Leg Swelling
- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Varicose Veins

Respiratory:
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Chest Congestion

Gastroenterology:
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Bloating/Belching
- ☐ Difficulty swallowing
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Blood in Stool

Urology:
- ☐ Difficulty Urinating
- ☐ Blood in Urine
- ☐ Urinary Urgency
- ☐ Frequent Urination
- ☐ Urinary Incontinence
- ☐ Dysfunction
- ☐ Nocturia

Dermatology:
- ☐ Rash
- ☐ Lumps
- ☐ Dry or Sensitive Skin

Neurology:
- ☐ Headache
- ☐ Tingling/Numbness
- ☐ Seizures
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Dizziness
- ☐ Gait Abnormality

Hematology:
- ☐ Swollen Glands
- ☐ Fatigue
- ☐ Loss of Appetite
- ☐ Easy Bruising

Musculoskeletal:
- ☐ Joint Swelling
- ☐ Joint Pain
- ☐ Leg Cramps
- ☐ Joint Stiffness

Psychology:
- ☐ Depression
- ☐ High Stress Level
- ☐ Suicidal Ideation
- ☐ Eating Disorder

Male Reproductive:
- ☐ Difficulty with Erection
- ☐ Difficulty with Ejaculation
- ☐ Diminished Sex Drive

Female Reproductive:
- ☐ Heavy Periods
- ☐ Sexually Active
- ☐ Dysmenorrhea
- ☐ Postcoital Bleeding
- ☐ Postmenopausal Bleeding

Patient Signature:_________________________________ **Date:** ________________

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Missed Appointment and Cancellation Policy

As a courtesy, please contact our office at least 24 hours in advance if you are unable to keep your scheduled appointment, to ensure that you will not be charged for the appointment.

Effective July 1, 2013, there will be a $35 fee for all missed appointments and a $100 fee for all missed diagnostic tests and procedures without 24 hours notice.

New patients will be charged $50 for a missed appointment without at least 24 hours notice.

Patient Name: ______________________**Date:** ___________

Signature: ____________________________

Thank you for your consideration