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TO ALL OUR PATIENTS
OUR NEW PRESCRIPTION POLICY

Please take all medicine bottles with you to each appointment. That is how we will know your exact medications and dosages. Also, please bring a list of your medications.

To reduce medication errors and make sure you always have your medication available, we urge you to fill out all your prescriptions during your office visits. This will ensure that your entire drug area is available to you, reconciled and reviewed by your doctors.

We will need your cooperation to implement this program.

Consult your PCP for prescriptions that are not related to your Cardiovascular Care.

Medicines not prescribed by our doctors:

- *Viagra*
- *Cialis*
- *Narcotics*
- *Painkillers*
- *Medications for depression or anxiety*

Signature: _____ Date: _____



Patient Demographic Information Form

Please fill out every space. If it does not pertain to you, please write N/A, for Not Applicable.

Patient Information			
<i>Patient's Name: First</i>	<i>Middle</i>	<i>Last</i>	<i>(Preferred)</i>
<i>Gender</i>	<i>Date of Birth</i>	<i>Social Security #</i>	
<i>Marital Status:</i> <input type="checkbox"/> <i>Married</i> <input type="checkbox"/> <i>Single</i> <input type="checkbox"/> <i>Divorced</i> <input type="checkbox"/> <i>Widowed</i> <input type="checkbox"/> <i>Separated</i> <input type="checkbox"/> <i>Partner</i>			
<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Home Phone Number:</i>	<i>Work Phone Number:</i>	<i>Cell Phone Number:</i>	
<i>Secondary Address</i>	<i>City:</i>	<i>State:</i>	<i>Zip Code</i>
<i>Alternate Phone Numbers:</i>		<input type="checkbox"/> <i>Name:</i> _____ <input type="checkbox"/> <i>Number:</i> _____	
		<input type="checkbox"/> <i>Name:</i> _____ <input type="checkbox"/> <i>Number:</i> _____	
		<input type="checkbox"/> <i>Name:</i> _____ <input type="checkbox"/> <i>Number:</i> _____	
<i>Patient's Email</i>			
<i>Preferred Language</i>	<i>Race</i>	<i>Ethnicity</i> <input type="checkbox"/> <i>Hispanic</i> <input type="checkbox"/> <i>non-Hispanic</i>	

Provider Information	
<i>Primary Care Physician</i>	<i>Referring Provider</i>
<i>Office Location</i>	

Communication	
<input type="checkbox"/> I authorize Cardiology Partners, and those parties acting on behalf of Cardiology Partners, to contact me about appointments and reminders for health services via: <input type="checkbox"/> Home Phone <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Text <input type="checkbox"/> Email Is it OK to leave medical information on your answering machine or voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Guardian/Power of Attorney	
Name (Last, First, Middle, Suffix)	
Emergency Contact Information	
Name	Relationship
Home Phone Number	Cell Phone Number

Employment			
Employer's Name		Phone Number	
Address	City	State	Zip Code
<input type="checkbox"/> Unemployed			
<input type="checkbox"/> Retired			

Guarantor/Insured			
Patient's Relationship to Guarantor/Insured			
Name (Last, First, Middle, Suffix)		Date of Birth	
Address	City	State	Zip Code
Employer		Social Security Number	



Insurance	
<i>Primary Insurance Company</i>	<i>Secondary Insurance Company</i>
<i>Subscriber's Name (Policyholder)</i>	<i>Subscriber's Name (Policyholder)</i>
<i>Subscriber's DOB</i>	<i>Subscriber's DOB</i>
<i>Relationship to Subscriber</i>	<i>Relationship to Subscriber</i>

Pharmacy Information			
<i>Primary Pharmacy Name</i>			
<i>Pharmacy Phone Number</i>		<i>Pharmacy Fax Number</i>	
<i>Address (or Cross Street)</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>



CARDIOLOGY PARTNERS HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Patient DOB: _____

Referring Physician: _____

Allergies/Intolerances	
Food Allergies:	Reaction:
①	
②	
③	
Medication Allergies	Reaction:
①	
②	
③	
Medication Intolerance	Reaction:
①	
②	
③	

Past Medical History			
<i>Cardiac History</i>	<i>if checked, when:</i>	<i>Risk Factors</i>	<i>When Onset:</i>
<input type="checkbox"/> Heart Attack		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Bypass Surgery		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Angioplasty/Stent		<input type="checkbox"/> Elevated Cholesterol	
<input type="checkbox"/> Treadmill/Stress Test		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Echocardiogram (Cardiac Ultrasound)		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Irregular Heart Rhythm		<input type="checkbox"/> Cancer	
<input type="checkbox"/> Congenital Heart Disease		<input type="checkbox"/> Anemia	
<input type="checkbox"/> Heart Murmur		<input type="checkbox"/> Bleeding Problems	
<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Eye Problems	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Weight Loss	
<input type="checkbox"/> Stroke/TIA		<input type="checkbox"/> Head/Nose/Mouth	
<input type="checkbox"/> Congestive Heart Failure		<input type="checkbox"/> Lungs	
<input type="checkbox"/> Valvular Heart Disease		<input type="checkbox"/> Gastrointestinal	
		<input type="checkbox"/> Skin	
		<input type="checkbox"/> Neurological	
		<input type="checkbox"/> Psychological	
		<input type="checkbox"/> Musculoskeletal	
		<input type="checkbox"/> Stress	



CARDIOLOGY PARTNERS

HEALTH HISTORY QUESTIONNAIRE (continued)

Review of Systems (check all that you have been treated for)	
<input type="checkbox"/> <i>Chest Pain</i>	<i>If checked, when</i>
<input type="checkbox"/> <i>Shortness of Breath</i>	<i>If checked, when</i>
<input type="checkbox"/> <i>Ankle Swelling</i>	<i>If checked, when</i>
<input type="checkbox"/> <i>Dizziness</i>	<i>If checked, when</i>
<input type="checkbox"/> <i>Fainting</i>	<i>If checked, when</i>
<input type="checkbox"/> <i>Other</i>	<i>If checked, when</i>

Social History	
<i>Occupation</i>	
<i>Do you use tobacco?</i> <input type="checkbox"/> <i>Past (Quit: _____)</i> <input type="checkbox"/> <i>Present</i> <input type="checkbox"/> <i>Never</i>	
<i>Packs per day? _____ Cans per day? _____</i>	<i>Exposed to secondhand smoke at home?</i> <input type="checkbox"/> <i>Past</i> <input type="checkbox"/> <i>Present</i> <input type="checkbox"/> <i>Never</i>
<i>Do you use alcohol?</i> <input type="checkbox"/> <i>Past (Quit: _____)</i> <input type="checkbox"/> <i>Present</i> <input type="checkbox"/> <i>Never</i>	<i>How many drinks per day? _____</i>
<i>Do you exercise?</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i> (Type _____) Frequency _____	
<i>Consume caffeine, tea, soda?</i> <i>Past Present Never</i>	<i>How many drinks per day?</i>
<i>Dietary Pattern</i> <input type="checkbox"/> <i>Unrestricted</i> <input type="checkbox"/> <i>Low Fat/ Cholesterol</i> <input type="checkbox"/> <i>Low Salt</i> <input type="checkbox"/> <i>Other</i> _____	

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY



I have been presented with a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted restrictions concerning the use and disclosure of my personal medical information:

Furthermore, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to medical assignment of benefits applies.

Patient Signature: _____ Date: _____

Patient refuses to sign this acknowledgment Date: _____

Patient Permissions to the Practice Sheet

	Yes		No	We may leave test instructions, medication refill information, or appointment information on your voicemail or answering machine.
	Yes		No	We may give test instructions, medication refill information, or appointment information to an immediate family member.
	Yes		No	We may discuss your medical condition and/or diagnosis with an immediate family member.
	Yes		No	We may fax/send your medical records to your primary care physician, Dr. _____
	Yes		No	We may fax/send your medical records and insurance information to a hospital, doctors office and/or relative

Patient Name : _____

Patient Signature : _____

Date : _____



By signing my name below:

- I hereby guarantee payment in full within thirty (30) days of all charges established by Cardiology Partners for services rendered to me or my dependent unless other arrangements satisfactory to Cardiology Partners have been made. This includes any charges that a third-party payer may determine to exceed usual and customary limits.
- I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs and other costs of collection, including but not limited to collection agency fees.
- I authorize Medicare, Medicaid, all relevant commercial payers to pay Cardiology Partners on my behalf for any services furnished to me or my dependent. I certify that I have read this assignment of benefits, that the information given by me is correct and that I agree to all of the provisions contained in it.
- The insurance information I have provided is current and correct. If this form is acknowledged and signed and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for the services in full and will need to file with the insurance carrier myself.
- I hereby consent to treatment by my cardiology partners provider (s). I understand that cardiology partners will release to my referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my conditioning care and as needed to process claims and for general health care operations. I agree that this consent is valid for all treatment and payment of said treatment for a period of twelve (12) months following execution of the Consent.
- I understand my insurance co-pay is due at the time of service, per my insurance company policy.

Uses and Disclosures of Health Information

I understand that _____ will use and disclose my personal health information to provide treatment, process payment claims, as necessary for healthcare operations (e.g., Performance Improvement, Utilization Review, manufacturers of surgically placed implants) or as required by law. This includes release of information to insurance carriers, 3rd party payers or their agents, with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV as may be necessary. Further, my information and medical records may be disclosed of members of the Hospital’s medical staff, identified primary care physicians or outpatient therapy department involved in my subsequent care and treatment. I authorize the release of my prescriptions/medication history from a third-party source and understand my prescriptions may be ordered electronically.

ACKNOWLEDGE RECIEPT OF THE NOTICE OF PRIVACY PRACTICES: _____ (Patient’s Initials)

Patient/Guarantor/Guardian Signature

Date



I, the patient/representative, agree not to bring a frivolous medical malpractice case or cause against the physician or physician's legal entity providing care. Furthermore, should a meritorious medical malpractice case of cause of action be initiated or pursued, I, the patient/representative, agree to use an expert medical witness (es) who adhere(s) to the guidelines and/or code of conduct defined by the specialty(ies) for expert witness in the area(s) of medicine who would typically have the background and experience to opine on such a case. In consideration for this, the physician, agrees to the same stipulation.

Patient/Guarantor/Guardian Signature

Date



NOTICE OF PRIVACY POLICIES FOR CARDIOLOGY PARTNERS, P.L.

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

Introduction:

This notice of privacy describes the personal use of your information that we collect. It describes how and when we use to disclose that information. It also describes your rights as they relate to your protected health information as defined by federal regulation.

Understanding Your Health Record Information

Each time you visit Cardiology Partners PL a record of your visit is made. Typically, this record contains your symptoms, examinations, and test results diagnosis, treatments and plan care or treatment. This information often referred to as your health or medical record serves as a:

- *Basis for planning your care and treatment*
- *Means of communication among many health professionals who contribute to your care.*
- *Legal documents describing the care you received.*
- *Means by which you or the third-party can verify that services billed were provided*
- *A tool in educating health care professionals*
- *A source of data for medical research*
- *A source of information for public health officials charged with improving the health of this state and the nation*
- *A source of data for our planning and marketing*
- *A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.*

Your Health Information Rights

Although your health record is the physical property of Cardiology Partners, the belongs to you. You have the right to information.

- *Obtain a paper copy of this notice of information upon request*
- *Inspect and copy your health record as provided for in 45CFR 164.524*
- *Amend your health record provided in 45 CFR 164.528*
- *Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.52845*
- *Request a restriction on certain uses and disclosure of your information as provided by 45 CFR 164.522*
- *Revoke your authorization to use or disclose health information except to extend that action has already been taken.*



Cardiology Partners is required to:

- *Maintain the privacy of your health information*
- *Provide this notice about your legal duties and our privacy practices*
- *Abide by the terms of this notice*
- *Notify you if we cannot meet a requested restriction*
- *Accommodate reasonable requests to communicate health information by mail or email*

We will not use or disclose your health information without your authorization, except as stated here. We will stop using or disclosing it if you revoke authorization.

For More Information or to Report A Problem:

If you have any questions and would like additional information you may contact the practice's Privacy Officer at 561-793-6100.

If you believe that your privacy rights have been violated, you can file a complaint with the Privacy Officer, or with the officer for Civil Rights, US Department of Health and Human Services. There will not be any retaliation for filing a complaint. The address for the OCR is listed below:

*US Department of Health and Human Services
200 Independent Ave SW
Room 509F, HHH Building
Washington, DC 20201*

Examples of Disclosures for Treatment Physicians and Health Operations

We will evaluate health information for treatment.

For example: information obtained by a nurse, physician, or other member of your health care team will be recorded and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations. Member of your health care team will then record the actions they took and their observation. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from any hospital.

We Will use Your Health Information for Payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We Will Use Your Health Information for regular health operations:

For example: Members of the medical staff, the risk of the quality improvement manager, or member of the quality improvement team may use information that identifies you, as well as your diagnosis, procedures and supplies used.

Business Associates:

There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory test, and a copy of services when we make copies of your records. When these services are contracted, we may disclose your health information to our business associate to the appropriately safeguard your information.

Directory:

Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and except for religious affiliation, to others who ask for you by name.

Notifications:

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general conditions.

Communication with family:

Health professional, using their best judgement may disclose to a family member, other relative, close friend or any other person you identify, health information relevant to that person's involvement in your case or payment related to your care.

Research:

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Direction:

We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Workers' compensation:

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or tother similar programs established by law.

Law Enforcement:

We may disclose health information for law enforcement purposes as required by law or in response to valid subpoena.

Federal Law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associates believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or public.



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REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
(PHYSICIAN'S NAME)

(ADDRESS)

(CITY) (STATE) (ZIP)

I REQUEST MY MEDICAL RECORDS BE RELEASED TO:

CARDIOLOGY PARTNERS, PL
3345 Burns Road Suit 306
Palm Beach Garden, FL 33410

PHONE: 561-626-1881
FAX: 561-967-0167/ 561-721-8605

PATIENT INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____

PATIENT'S SIGNATURE: _____