Cardiology Associates of Stuart

1027 SE Ocean Blvd., Stuart, Florida 34996-2576
561 NW Lake Whitney Place, Suite 103, Port Saint Lucie, Florida 34986-1624
Phone (772) 781-0222 Fax (772) 781-0008

PLEASE COMPLETE THESE FORMS AND BRING THEM WITH YOU TO YOUR VISIT, THANK YOU!

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

OTHER ADDRESS: _____

HOME PHONE: _____ **WORK PHONE:**_____**CELL:** _____

SOCIAL SECURITY: _____ **M / F MARITAL STATUS: S / M / W / D SPOUSE:** _____

RACE: CAUCASIAN / AFRICAN AMERICAN / ASIAN / UNKNOWN / OTHER

ETHNICITY: CAUCASIAN / HISPANIC-LATINO / UNKNOWN / DECLINE

EMAIL: _____ **PREFERRED PHARMACY & PHONE #:** _____

EMPLOYER: _____ **FULL TIME / PART TIME / RETIRED** **RETIREMENT DATE:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

PRIMARY INSURANCE COMPANY: _____ **PHONE:** _____

ADDRESS: _____

INSURANCE ID NUMBER:_____ **GROUP NUMBER:** _____ **SPECIALITY COPAYMENT: $**_____

INSURED NAME: _____ **RELATIONSHIP: SELF / SPOUSE / CHILD / OTHER / STUDENT**

SECONDARY INSURANCE COMPANY: _____ **PHONE:** _____

ADDRESS: _____

INSURANCE ID NUMBER:_____ **GROUP NUMBER:** _____ **SPECIALITY COPAYMENT: $** _____

INSURED NAME: _____ **RELATIONSHIP: SELF / SPOUSE / CHILD / OTHER / STUDENT**

LIFETIME SIGNATURE: I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO BE RELEASED TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIER AND ANY INFORMATION NEEDED FOR THE RELATED INSURANCE CLAIM. 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. REGULATIONS PERTAINING TO INSURANCE OR MEDICAL ASSIGNMENT OF BENEFITS APPLY. THE INFORMATION I AM PROVIDING IS TRUE AND ACCURATE. IF THIS INFORMATION IS FOUND TO BE FALSE, I WILL BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED. THE DOCTOR/PATIENT RELATIONSHIP IS BASED ON TRUST AND OPEN COMMUNICATION. IN ORDER FOR YOUR PHYSICIAN TO MAKE A VALID DIAGNOSIS AND TREATMENT, THE INFORMATION I PROVIDE MUST BE TRUE AND COMPLETE.

PATIENT SIGNATURE: _____ **DATE:** _____

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE _____ TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPPLICATIONS FOR FINANCIAL BENEFITS. PURSUANT TO FLORIDA LAW & HIPPAA, NO INFORMATION MAY BE REDISCLOSED TO ANY OTHER PERSON WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE UNDERSIGNED. SIGNING THIS FORM IS VOLUNTARY & WILL NOT AFFECT TREATMENT. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, PROVIDING THAT THE INFORMATION HASN'T ALREADY BEEN RELEASED. THIS AUTHORIZATION DOES NOT EXPIRE UNLESS THE DATE IS WRITTEN HERE _____. CARDIOLOGY ASSOCIATES OF STUART IS HEREBY RELEASED FROM RESPONSIBILITY FOR MAINTAINING THE CONFIDENTIALITY OF THE INFORMATION ONCE RELEASED FROM THIS OFFICE
.

PATIENT SIGNATURE: _____ **DATE:** _____

MEDICAID DEDUCTIBLE WAIVER: I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE FOR WHICH MEDICAID DOESN'T ALLOW.

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME: _____ DATE OF BIRTH: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

REASON FOR VISIT: _____

LIST MEDICATIONS (NAME & DOSAGE) OR ATTACH A COMPLETE LIST:_____

_____

_____

ALLERGIES: _____

HAVE YOU EVER USED TOBACCO? Y / N HOW MUCH? _____ HOW MANY YEARS?____

QUIT DATE:_____

DO YOU DRINK ALCOHOL? Y / N HOW MUCH? _____ DO YOU DRINK CAFFEINE? Y / N HOW MUCH? _____

PERSONAL MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING? CHECK ALL THAT APPLY(ADD DATES & HOSPITAL NAMES IF APPLICABLE)

_____ CHEST PAIN/PRESSURE

_____ SHORTNESS OF BREATH

_____ HYPERTENSION

_____ HEART ATTACK

_____ CVA (STROKE)

_____ TIA

_____ HIGH CHOLESTEROL

_____ DIZZINESS/FAINTING

_____ WEAKNESS/FATIGUE

_____ PALPITATIONS/FLUTTERING

_____ LEG PAIN OR SWELLING

_____ BYPASS SURGERY (CABG)

_____ VALVE SURGERY

_____ PACEMAKER

_____ DEFIBRILLATOR (AICD)

_____ HEART CATHETERIZATION

_____ STRESS TEST

_____ DEPRESSION/ANXIETY

_____ EMPHYSEMA/COPD

_____ PNEUMONIA

_____ TUBERCULOSIS (TB)

_____ HEPATITIS TYPE: _____

_____ HIV/AIDS

_____ DIABETES

_____ GLAUCOMA

_____ CATARACTS

_____ HEARING PROBLEMS

_____ ULCER

_____ BLOOD IN STOOL

_____ KIDNEY STONES/INFECTION

_____ PROSTATE PROBLEMS

_____ GOUT

_____ SEIZURES

_____ EPILEPSY

_____ ECHOCARDIOGRAM **_____ USE OF A: CANE / WALKER /WHEELCHAIR**

_____ CAROTID ULTRASOUND **_____ CHILDREN-HOW MANY? _____**

_____ OTHER: _____

PATIENT NAME: _____ DATE OF BIRTH:_____

LIST PREVIOUS SURGICAL PROCEDURES

PLEASE LIST THE KIND OF SURGERY, DATE OF SURGERY & NAME OF HOSPITAL, INCLUDING CITY & STATE

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY: PLEASE CIRCLE THE FAMILY MEMBER WHO HAS OR HAD THE FOLLOWING:

HEART ATTACK	**MOTHER**	**FATHER**	**SISTER**	**BROTHER**	**CHILD**
STROKE	**MOTHER**	**FATHER**	**SISTER**	**BROTHER**	**CHILD**
HIGH CHOLESTEROL	**MOTHER**	**FATHER**	**SISTER**	**BROTHER**	**CHILD**
HYPERTENSION	**MOTHER**	**FATHER**	**SISTER**	**BROTHER**	**CHILD**
CANCER	**MOTHER**	**FATHER**	**SISTER**	**BROTHER**	**CHILD**
DIABETES	**MOTHER**	**FATHER**	**SISTER**	**BROTHER**	**CHILD**

DO YOU HAVE A LIVING WILL? YES / NO IF YOU DO, PLEASE PROVIDE A COPY OF IT FOR OUR RECORDS

DO YOU HAVE A HEALTH CARE SURROGATE? YES / NO WHO?_____

CONTACT PHONE NUMBER: _____

GENERAL INFORMATION:

WHAT IS YOUR HEIGHT? _____ WHAT IS YOUR WEIGHT? _____

DO YOU EXERCISE? Y / N HOW OFTEN: _____TYPE OF EXCERCISE: _____

WHAT OTHER INFORMATION WOULD YOU LIKE FOR US TO KNOW? _____

_____

_____

_____

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FINANCIAL POLICY

Thank you for choosing Cardiology Associates of Stuart as your health care provider. We ask that you read and sign our financial policy, so that there is no confusion regarding fees from our office. We ask that you provide complete insurance information. We may accept assignment of insurance benefits. We may require that a portion of the fee be paid at the time of service. Collection costs are expensive and we try to eliminate additional billing when possible. Please remember that your insurance policy is a contract between you and your insurance company. If your insurance company does not pay your claim in full, you will be billed for the remaining balance. All co-payments and deductibles are due at the time of service.

All checks that are returned from your bank are subject to a $40.00 processing fee. Any fees that are not paid in a timely manner will be turned over to a outside collection agency.

I have read and agree to this Financial Policy.

_____ _____ _____

Print Name **Signature** **Date**

CONFIDENTIALITY WAIVER-PRIVACY POLICY:

I **DO / DO NOT** allow Cardiology Associates of Stuart to speak to:

_____ , my _____ about any test results and/or medical conditions.

I **DO / DO NOT** allow Cardiology Associates of Stuart employees to leave a message on my answering machine regarding my test results.

We do not sell any patient information to any other entities.

This waiver will remain valid until I document in writing otherwise.

_____ _____

Signature **Date**

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I _____ have received a copy copy or have seen
(Print your name)

the CAS Privacy Notice. This policy is to meet HIPAA compliance requirements. The current policy will be posted in the CAS lobby and/or will be given to a patient upon request.

_____ _____
Signature Date

_____ Refuse to Sign

_____ I am not interested in this information