KSC Cardiology, P.A.

We manage the world of Cardiovascular Disease

Last Name:	**First Name:**	**Middle Initial:**
Mailing Address:	**City:**	**State/Zip Code:**
Residential Address:	**City:**	**State/Zip Code:**
***Home Phone :*( ) - -**	***Cell Phone:* ( ) - -**	
Date of Birth: / /	**Social Security No. - -**	
Sex: M❑ F❑	**Marital Status: S M D W**	

Employment Status:
❑Full-time ❑Part-time
❑Not-Employed
❑Self-employed ❑Retired

Race:
❑ American Indian ❑ Asian ❑ White
❑ African American/Black ❑ Hispanic
❑ Native Hawaiian/Pacific Islander ❑ Other

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Language Preferred:** _____

KSC Cardiology is now offering our patients secure internet access to medical information on line. By providing your e-mail address, you may view your personal health information, request refills, view your statement, and even message clinical staff at any time from the comfort of your home or any smart phone.

E-Mail Address: _____

What pharmacy would you like us to send your prescriptions to?

Pharmacy Name:	**Phone:**
Pharmacy Address:	

Do you have an Advance Directive Order? **( ) NO** **( ) YES**

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Release of Personal Health Information (PHI)

_____

PLEASE PRINT PATIENT NAME:

The Health Insurance Portability & Accountability Act (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential.

The doctors and staff at KSC Cardiology, PA may release information on my health to the following individuals:

( ) Spouse: _____ ***Phone No.*** _____

( ) Other: _____ ***Phone No.*** _____

I understand that if my protected health information is disclosed to someone who is not required to comply with the federacy privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing and addressed to my physician at this practice. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that my refusal to do so will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

_____ _____

Patient Signature: **Date:**

Medical History Form 1

Do you have any of the following? ( ) History of Smoking ( ) Currently Smoking ( ) Hypertension ( ) Diabetes

( ) High Cholesterol ( ) Family history of heart disease

Reason for Consultation: ( ) Abnormal EKG ( ) Chest Pain/Tightness ( ) Fainting ( ) Heart Attack ( ) Heart Failure ( ) High Blood Pressure ( ) Irregular /Rapid Heart Rate ( ) Shortness of Breath ( ) Positive Stress Test

( ) Consultation ( ) Surgery Clearance ( ) Surgery Clearance ( ) Hospital Follow Up

Other_____

List All Symptoms:

_____

_____

Date Symptom(s) Began:

_____

What makes it worse:

_____

Frequency of Symptom(s):

_____

What relieves it:

_____

What brings it on:

_____

Associated Symptom(s):

_____

Past Medical History	**Date:**

Family Medical History	**Age**	**Cause of Death**
Father		
Mother		
Brothers		
Sisters		

Medical History Form 2

Does anyone assist you with daily activities?

( ) Yes

( ) No

ASSISTIVE DEVICES

( ) Walker ( ) Cane

( ) Wheelchair

( ) None

ALCOHOL

( ) Never

( ) Current

( ) Beer(s) per week: _____

( ) Liquor per week _____

( ) Wine per week _____

how many years alcohol free?

_____

SMOKING

( ) Never

( ) Current

Packs per day? ____

( ) Previous smoker

How many years smoke free?

_____

HEART

( ) PALPITATIONS

( ) CHEST PAIN

( ) SHORTNESS OF BREATH

( ) SWELLING

GENERAL

( ) WEAKNESS

( ) FATIGUE

( ) CHILLS

( ) NIGHT SWEATS

( ) FEVER

LUNGS

( ) COUGHING BLOOD

( ) COUGH

( ) WHEEZING

( ) DIFFICULTY BREATHING

NEUROLOGICAL

( ) SEIZURE

( ) VERTIGO

( ) DIZZINESS

( ) SYNCOPE (FAINTING)

( ) UNSTEADINESS

HEMATOLOGY

( ) ANEMIA

( ) EASY BRUISING

( ) BLEEDING

ENDOCRINE

( ) COLD INTOLERANCE

( ) HEAT INTOLERANCE

( ) HAIR CHANGES

( ) APPETITE CHANGES

( ) EXCESSIVE THIRST

OTHER

_____

_____

_____

_____

DO YOU HAVE ANY OF THE FOLLOWING? STENTS, PACEMAKER, DEFIBRILLATOR OR IMPLANTABLE MEDICAL DEVICES?

( ) N/A ( ) YES

_____

_____

MEDICATIONS/ALLERGIES

If you did not bring either a printed list of your medication or the medicine bottles themselves to your appointment, please list all medications you are currently taking. Include all medications even over the counter and vitamins.

LIST ANY ALLERGIES:

_____

_____

_____

_____

_____

_____

Please list all Current Medications

Drug name
1
2
3
4
5
6
7
8
9
10

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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from designated third-party payers.**
- **Conduct normal health care operations such as quality assessments or evaluations and physician certifications.**

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abounded to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient Name : _____ **Date :** _____

Patient Signature : _____ **Date :** _____

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Financial Agreement

AGREEMENT FOR TREATMENT I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement, I agree to pay all the applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. I, the responsible party also understand any unpaid balances will be sent to a 3rd party collection agency with an additional 30% collection fee added to the unpaid balance. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third-party insurer or other payer. I understand that I am responsible for giving the correct insurance information or otherwise I will be considered self-pay.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER I hereby authorize KSC Cardiology and its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all of part of the provider charges. I authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care. I authorize and request that payment of any third party or insurance company benefits be made directly to KSC Cardiology for any services furnished to the patient. The signature below shall suffice for all insurance forms on a continuing basis.

CONSENT FOR TREATMENT By signing below I, the undersigned patient (or authorized representative), consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and its healthcare providers.

*Some contract health plans (HMO, PPO, IPA, etc.) require a co-payment at the time of service-Please have this ready prior to your visit as well as any current balance due. If copay or past due balance is not paid at the time of visit, patient may be required to reschedule the appoint

Patient Name : _____ **Date :** _____

Patient Signature : _____ **Date :** _____

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Medical Records Release Form

Please fax records to KSC Cardiology at (863) 299-6158.

Patient Name: _____ **Date of Birth:** _____

Social Security No: _____ **Phone:** _____

The information you may release subject to this signed release form is as follows:

☐ Complete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Report	☐ Treatment Record	☐ Operative Reports
☐ Hospital Records	☐ Medication Record	☐ All Cardiac Testing/Records

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility/entity listed below.

I Authorize the release of my medical records by the organization listed below:

_____ _____

Physician/Facility: Address:

_____ _____

Phone: Fax:

I understand this authorization will expire, without my revocation, one year from, the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

Patient's Signature: **Date:**

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No Show Policy

If you must cancel your appointment, we respectfully request 24-hour notice.

No Show, or appointments cancelled without 24-hour notice, will incur the following fees:

- **Follow Up Appointments $35.00**
- **Diagnostic Testing $50.00**
- **Nuclear Appointments $150.00**
- **Surgical Procedures $200.00**

In order to be respectful of your fellow patients, please call KSC Cardiology at (863) 508-1101 as soon as you know you will not be able to make your appointment. Please understand that appointment times are limited. Your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If cancellation is necessary, we require that you call **(863) 508-1101** at least 24 hours in advance between the hours of 8am-5pm Monday-Friday.
If necessary, you may leave a detailed voicemail message.

No-Show A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a No-Show fee.

Late Cancellations A cancellation is considered late when the appointment is cancelled less than **24 hours** before the appointed time.

- **The third time a patient No shows an appointment, the patient be withdrawn from the practice via certified mail.**

In the event of a true, unavoidable emergency, we will waive the No Show fee once documentation has been provided to KSC Cardiology.

_____ _____

Patient Name : **Date :**

_____ _____

Patient Signature : **Date :**