Orlando Heart &Vascular Center

11616 Lake Underhill Road, Suite 21S Orlando, Florida 32825
Office: (407) 482-7788 Fax: (407) 482-8698

PATIENT FACE-SHEET

FIRST NAME: ____________________ MIDDLE IN: ____ LAST NAME:_________________________

DOB: ___/___/___ SSN: ___/___/___ HOME PHONE: ( )_______________ OTHER: _______________

HOME ADDRESS: ____ Zip Code: ___________________

EMAIL ADDRESS: ____

MARITAL STATUS: MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOWED ( )

EMERGENCY CONTACT NAME: _______________________ PHONE NUMBER: ( ) _______________

RELATIONSHIP: SPOUSE ( ) CHILD ( ) PARTNER ( )

Ethnic Group: ___________________ Race: ___________________ Language: _________________

Employer: ____________________________________ Phone#:_______________________________

Address:____

PRIMARY CARE PHYSICIAN: ____________________________________ PH: _______________

REFFERED BY A DOCTOR YES ( ) NO ( ) NAME/PHONE: DR: _______________ PH: __________

INSURANCE INFORMATION

PRIMARY INSURANCE: _______________ ID: _______________GROUP NUMBER: __________

SUBSCRIBER NAME: ________________ RELATION TO PT: SPOUSE ( ) CHILD ( ) PARTNER ( )

SUBSCRIBER DOB: ___________________________ SUBSCRIBER SSN#: ___________________

NETWORK: IN OUT (Any benefits if out of network?) YES NO COPAY: ____ DEDUCTIBLE: ______

*NEED AUTH FOR OFF VISIT: YES NO *NEED AUTH FOR DIAGNOSTIC STUDIES: YES NO

SECONDARY INSURANCE:________________ ID: ______________ GROUP NUMBER: ________

SUBSCRIBER NAME: ________________ RELATION TO PT: SPOUSE ( ) CHILD ( ) PARTNER ( )

SUBSCRIBER DOB: ___________________________ SUBSCRIBER SSN#: ___________________

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Health History (circle all that apply)

Constitutional
Fatigue
Fever
Chills
Night sweats
Weight gain/loss

Eyes
Glasses/Contacts
Blurred vision
Eye pain
Sensitivity to light
Cataracts
Glaucoma
Eye drainage

Ears/Nose/Throat
Ear pain
Hearing problems
Ears ringing/buzzing
Frequent runny nose
Hoarseness
Sore throat
Bleeding gums
Tooth pain
Nosebleeds (Epistaxis)

Cardiovascular
Claudicating
Difficulty breathing
Edema (specify where) _______________
Palpitations
Nocturnal dyspnea
Congestive heart failure
Murmur
Cyanosis (bluish color)
Clubbing
Varicose veins

Gastrointestinal or Urinary
Abdominal pain
Anorexia
Difficulty swallowing
Constipation
Diarrhea
Heartburn
Vomiting blood
Hemorrhoids
Pancreatitis
Urinary bladder problems
Prostate trouble
HX frequent UTI's
Nocturia
Hematuria
Genital lesions
Nausea
Vomiting
Gallbladder
Appendectomy
Hepatitis jaundiced
Liver problems
Stomach ulcers
Impotence
Excessive urinating
Black/tarry stools

Respiratory
Cough (acute / chronic)
Coughing blood
Asthma
Wheezing
Bronchitis
COPD (chronic obstructive lung disease)
Emphysema
Pneumonia
Sinuses problems/hay fever
Tuberculosis (exposure)
Shortness of breath

Musculoskeletal
Arthritis
Joint stiffness
Limb pain
Joint pain
Back pain
Osteoporosis

Neurological
Alzheimer's
Migraines/headaches
Dizziness/vertigo
Seizures
Parkinson
Strokes/CV A
Depression
Anxiety
Mental illness
Ataxia
Fainting
Memory loss
Tremor
Bi-polar
"Feeling stressed"
Suicidal thoughts
Sleep disturbance
Personality change
Crying spells

Hematological/Lymphatic
Easy bruising
Excessive bleeding
Lymphadenopathy
Blood transfusion

Endocrine or Sexual
Diabetes
Hysterectomy/menopause
Sexually transmitted disease
Hyperthyroid
Hypothyroid
Swelling hands/feet
Hair loss
Heat/cold intolerance
Abnormal hairiness
Increased skin pigmentation
Infertility
Excessive thirst
Excessive sweating

Integumentary
Jaundice
Itching
Rashes
Dry skin
Acne
Fungal infection
Warts

Other
Seasonal allergies
HIV
AIDS
Anemia
Obesity
Sickle cell
Cancer

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Have you ever been diagnosed with **high blood pressure**? Yes No If yes, when? __________________

If you are taking medication for blood pressure, how long have you been taking it? ________________

Have you been diagnosed with **high cholesterol**? Yes No

What was your last cholesterol level? __________________ Triglyceride level? __________________

If you are taking medication for your cholesterol, how long have you been taking it? _________________

Women only

Are you post-menopausal? Yes_____ No_____ Have you had a hysterectomy? Yes_____ No______

Surgical History (include date and type):

Type	When	Where

Personal History

Please specify amount of daily intake (cups, glasses, etc.)

Do you drink alcohol? _____ Beer? _____Wine? _____ For how long? _____

Do you drink coffee? _____ Tea? _____ Soda (with caffeine)? _____

Marital Status? Married Single Divorced Widowed

Live with (check all that apply): Spouse ____ Children (how many?) ____ Roommate ____ Alone ____

Employment Status: Employed ____ Unemployed ____ Retired ____ Other ____

Occupation(s): ____

Do you exercise regularly? ________What type? ________ How frequently? ___________

Illicit/ Street drug use? ________ What type? ________ How frequently? __________

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Family History

Please be as specific as possible:

	Living: Yes or No	Deceased Cause	Age	Overall Health
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Mother				
Father				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

Any other relatives (Aunts, Uncles) with significant history? ________________________

Please list all medications you are currently taking (including multivitamins):

Name	Dosage/Strength	Times Daily

Allergies: ____

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Date: ___________ **Patient's Full Name:** _____________________________ **Patient's Age:** ________

Referring Physician: ____________________________ **Reason for Consult:** ____________________

Have you had or are you having any of the following complaints of:

Chest Pain/Discomfort: Yes No

Shortness of Breath: Yes No

If yes, is it worse when you lie down? Please explain ____

Heart Failure: Yes No

Heart Murmur: Yes No

Stroke: Yes No If yes, give dates: ___________

Childhood heart disease: Yes No

Rheumatic heart disease: Yes No

Risk Factors

Tobacco Use: Yes No What type(Cigars, pipes, cigarettes)?

How many packs/cigarettes daily? ________ For how long? _________ When did you quit? ________

Palpitations: Yes No

Heart Attack: Yes No If yes, give dates: ___________

Blacking Out: Yes No

Heart Valve: Yes No

Coronary Angiogram/Angioplasty/PTCA, stent: Yes No If yes, give dates: ___________

Open Heart Surgery: Yes No If yes, give dates: ___________

Have you ever been diagnosed with Diabetes: Yes No If yes, give dates: ___________

Average Sugar: ___________

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Dear Patient,

We want to make you aware of a condition that may affect you. As many as 12 million Americans have Peripheral Arterial Disease (PAD). It is a condition in which the arteries that carry blood to the muscles of the legs become narrowed or blocked due to the buildup of plaque. Blood flow becomes sluggish and poor circulation in the legs, feet and toes may result. This may then lead to cramping, discomfort or possibly a mild "fatigue" in the legs which can limit walking distance, speed, and overall ability. This is the same disease process that causes blockages in the heart.

Unfortunately, many people with PAD go dangerously unrecognized and may have a higher risk for a heart attack, stroke, or even amputation. The symptoms of PAD may be subtle and are often mistaken for arthritis, being "out of shape," or as part of the normal aging process. Many times it can be simply diagnosed by performing a calculation after taking a blood pressure in your arms and at your ankles.

Please take a moment to answer the questions below so that we may briefly screen you for PAD. If you have any questions or concerns regarding PAD and your risk, or would just like more information please do not hesitate to ask.

1. Do you experience discomfort or aching in the muscles of your legs when you walk that is relieved by rest? YES NO
2. Do your legs ever feel fatigued or heavy when walking or are active? YES NO
3. Do you ever need to stop and rest when walking or have difficulty keeping up with others? YES NO
4. Do your feet or toes bother you on most nights while lying in bed with relief when they are dangled at the edge of the bed? YES NO
5. Any prior ulcers on your feet or lower legs? YES NO
6. Would you have difficulty or require assistance doing any of the following?

	No Difficulty	Some Difficulty	Unable
7. Walking one block?	1	2	3
8. Climbing one flight of stairs?	1	2	3
9. Walking at an increased speed?	1	2	3

10. Please check if you have a history of the following.

[ ] Diabetes or "borderline" diabetes
[ ] Age 70 years
[ ] Smoking or history of smoking or tobacco use

Thank you!

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ARE YOU SLEEPY AND TIRED ALL THE TIME?

Take the Epworth Sleepiness test and discuss the result with your doctor.

Patient Name: ____ **DOB**: ___________________

Phone #: ___________________ **Email**: ____

Height: __________ **Weight:** ___________ **BMI:** ___________ **Neck Circumference:** _____________

SITUATION: *Refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.*	**CHANCE OF DOZING:** • 0 = would never doze • 1 = slight chance of dozing • 2 = moderate chance of dozing • 3 = high chance of dozing
Sitting and Reading	
Watching TV	
Sitting, inactive, in a public place	
As a passenger in a car for an hour	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
	Total Score out of 24:

SCORE ANALYSIS

- *Score of 1-6: you're getting enough sleep*
- *Score of 4-8: you tend to be sleepy during the day; this is the average score*
- *Score of 9-15: you are very sleepy and should seek medical advise*
- *Score of 16 or greater: you are dangerously sleepy and should seek medical advise*

Patient Signature: ____ **Date:** __________________

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HIPAA Notice of Patient Rights

Orlando Heart & Vascular Center, LLC has a policy of complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Our objective is to be 100% compliant at all times. The following method of operations will be used to ensure privacy of a patient's Protected Health Information (PHI).

1. Based on HIPAA guidelines your medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without your (and/or legal guardian's) signed authorization.
2. After review of your records if you disagree with any of the documentation in the records you have the option of writing your own documentation to be placed in the chart.
3. If an appointment with another medical provider is required, only the necessary information to schedule an appointment will be provided.
4. If you elect to not allow any other member of your family access to your records you have the right to notify our office. The notice must be in writing. If you wish to provide access to your records to a designated individual you may also provide that notice in writing.
5. Our office will not provide any information about you or your medical condition to any other party besides other medical providers to whom you have been referred for treatment without your specific authorization.
6. f you are chosen to be a part of any research program you will be required to sign additional authorizations and releases so that PHI may be used in the program.
7. Under HIPAA rules, we may use the necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignment allows a practice to file insurance on your behalf.
8. There will be certain circumstances where public health authorities and health oversight agencies may require a copy of your records. They are authorized under law to collect that information and we are required to furnish a copy of your PHI.
9. You may review your records by scheduling a time with the office. We need at least 15-day written notification to schedule a time slot with a staff member.
10. All efforts will be taken to ensure that your PHI will not be shared with any unauthorized persons.
11. If you are on active duty military or are called to active duty military, under federal laws we are required to supply a copy of your record.
12. If you should have any questions concerning any of the above statements, please contact any of the staff at Orlando Heart & Vascular Center, LLC.

Print Patient Name: ____ **DOB:** ________________

Signature of Patient: ____ **Date:** ________________

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Financial Policy

PLEASE READ THOROUGHLY AND SIGN BELOW

Upon Check-in, we will collect your deductible, co-pay, non-covered services, or percentage of your responsibility. Please be prepared to pay prior to services being rendered. We reserve the right to refuse checks in the office at any time. As copayments are an insurance requirement, we cannot bill you for these. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable at the time the statement is issued.

Please be as thorough with your insurance information as possible if you expect us to file for you. Bring your insurance card with you and any authorization information you may have, without these we will be unable to see you! If your insurance requires a referral or authorization from your Primary Care Physician, (PCP), you are responsible for obtaining the referral. Failure to obtain an authorization of referral may result in reduced or non-payment, which you will ultimately be responsible for. As a courtesy, we will file your insurance and it is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should. **Remember, insurance coverage is a contract between you and your insurance company, and the company determines your eligibility and amount of coverage based on your plan. You are ultimately responsible for understanding the stipulations of your contract with your insurance.**

MEDICARE PATIENTS: We will bill Medicare as well as secondary insurance but if payment is not received from your secondary insurance within 45 days you will be notified and may be expected to pay our office the balance due. It will then be your responsibility to contact your insurance for reimbursement.

SELF-PAY PATIENTS: (This category includes those patients with no insurance and those who have an indemnity plan whom wish to file their own insurance.) Payment for medical services is expected on the day of service. We accept Visa, MasterCard and Discover as well as cash, and money orders. If you are unable to pay for the services in full you must contact our office to make a payment arrangement prior to your appointment.

Balances and Statements: If you have a balance on your account, we will send you a statement. We will be more than happy to make monthly payment arrangements to settle the debt. We prefer your account be paid in full within a 12-month period, and effective June I, 2011, there will be a 5% fee for any account that exceeds that timeframe. After 3 attempts to collect without a response, your account is handed over to an external collection agency and you will be required to settle the account with the collection agency.

Returned Checks: Any check that is returned for Non-Sufficient Funds or Stop Payments are subject to a $35 charge. At that time we can only accept cash or credit card payments, and payment must be made within 10 business days or be subject to collection action.

Medical Records: You will need to make the request in writing, and pay a reasonable fee of $1 per page for the first 25 pages, 25 cents for every page thereafter.

Equipment: Holter/MCOT monitors are the responsibility of the patient once they leave OHVC premises. We kindly request our equipment to be returned within 24 hours of the last day the monitor was worn. Failure to return the equipment will result in a **$50 fee per day that the equipment is held** as this prevents us from providing care to the next patient who needs the monitor. There will be a charge of **$3500.00 for lost, damaged or unreturned monitors**.

Any questions regarding this or any other office policies please ask our staff prior to your appointment.

Patient Signature: ____ **Date:** _______________________

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OFFICE POLICIES

NO SHOW & CANCELLATION POLICY

Please be advised, our cancellation and late rescheduling policy mandates that patients must notify our office **24 HOURS PRIOR** to their appointment date. Patients cancelling or rescheduling venous, Cathlab, PET, and hospital procedures must provide notice **ONE WEEK PRIOR** to their scheduled appointment.

Failure to notify our staff within the allotted time frame, will result in an added fee as specified below.

* ***Must speak with a live person***. Messages left on our voicemail and answering service are insufficient. *

NO SHOW FEE'S:

Patients who "**no show**" for their office visit or ABI appointment(s) will be charged a **fee of $50.00**

Patients who "**walk out**" of their appointment will **forfeit** their co-pay as well as incur a **fee of $50.00**

A **fee of $150.00** will be applied for failure to keep appointments with diagnostic studies. These procedures require us to purchase special orders, reserve time, and schedule personnel for the service. These supplies are **NOT** refundable. Thus, include the following tests:

- Ultrasounds (Echocardiogram, Carotid Doppler, Venous Doppler, Arterial, etc.)
- Nuclear or Treadmill Stress Tests, Petscan
- Any other diagnostic studies performed in our office

Failure to show up to an outpatient Cathlab appointment or cancel/reschedule within the allotted time of one week prior will incur a **$300.00 fee.**

Failure to show up for any hospital appointments with our providers or cancel/reschedule within the allotted time of one week prior will incur a **$100.00 fee**.

A $100.00 deposit is required to reserve your appointment time for a venous procedure(s) and Petscan. If you need to cancel your procedure, it **MUST** be done within **a minimum of 5 business days prior to the procedure date.** If you do not cancel/ reschedule your procedure within this time frame, **you will lose your deposit.** If you reschedule your procedure, you will need to put down another deposit, if you lost your deposit for failure to adhere the time schedule mentioned above. If you do not cancel within the allotted time, you will forfeit your deposit. Otherwise, it will be returned to you on the procedure day, or after all your procedures are done.

TECHNOLOGY USE:

Florida law prohibits recording of medical office visits without prior consent from the provider. Unauthorized audio or video recording may lead to HIPPA violation of other patients. The patient must inform and seek consent from the provider prior to making an attempt for audio or video recording. Audio and/or video recording is strictly prohibited during office visits.

By signing below, you acknowledge and agree to follow our office policies to regarding technology use, no-show and/or cancellation fees.

Patient Name: ____ **Date:** _____________________

Patient Signature: ____

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Authorization for Release of Information

Name: __________________________ DOB: _____________________ SS#: _____________________

Give authorization for Orlando Heart and Vascular Center, LLC to (CHECK ONE ONLY):

__ Obtain my records from: ____

__ Release my records to: ____

Records Needed:

☐ Office Visit ☐ Labs ☐ Stress ☐ Echo ☐ Ekg ☐ Cath ☐ Holter ☐ All Records

Name of person or facility receiving: ____

Address: ____

Phone: ____________________________ Fax: ____________________________

I authorize Orlando Heart and Vascular Center to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Orlando Heart and Vascular Center to release all medical information to my referring physician and my primary (family) physician. I authorize Orlando Heart and Vascular Center to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Orlando Heart and Vascular Center.

I agree that these provisions will remain in effect until I provide written revocation to Orlando Heart and Vascular Center.

Signature of Patient/Legal Guardian: _____________________________ Date: _________________

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HIPAA AUTHORIZATION FORM

______________________________	______________________________
Patient's Full Name	**Patient's Date of Birth**
______________________________	______________________________
Social Security Number	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   ____
   The following person (or class of persons) may receive disclosure of protected health information about me
   ____
   Name and Phone Number:
   ____
2. The specific information that should be disclosed is (please give dates of service if possible):

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES. DISCLOSE THIS INFORMATION * ________________________
NO, DO NOT DISCLOSE THIS INFORMATION * _________________

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Orlando Heart & Vascular Center, LLC. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for ____
6. This authorization expires on _____________________, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: ____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places*

______________________________	______________________________	______________________________
Signature of Patient* (The person about whom the information relates)	**Date of Patient's Signature**	**Date of Birth or Social Security Number**
______________________________	______________________________	______________________________
Signature of Guardian * or Personal Representative or Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

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HIPAA – PATIENT CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with **ORLANDO HEART AND VASCULAR CENTER., "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient Name: *(please print)* ____________________

Patient Signature *(or legal representative; proof may be requested)* ____________________

Date: ____________________

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **ORLANDO HEART AND VASCULAR CENTER., (OHVC)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **OHVC** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **OHVC** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **OHVC** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is: ____________________

My Consented Mobile Number For Text Messaging is:

____

Patient Signature: ____________________ **Date:** __________

IN CASE OF EMERGENCY: *Please call 911 or proceed to the nearest emergency room*.

Do not use this way of communication for that purpose.