

**CONFIDENTIAL PATIENT INFORMATION**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Sex: (Circle one) Male / Female**

**E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: (Circle one) Single Divorced Married Widow(er)**

**Race \_\_\_\_\_\_\_\_\_Primary Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Will you need interpreter? Yes No**

**Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_Ph#:\_\_\_\_\_\_\_\_\_\_\_**

**Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**

**List below, to whom this office may speak with regarding your medical care and treatment-**

1. **Name and phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Name and phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Policy Holder Information:**

**Policy Holder Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have an Advance Directive? (Circle) Yes No. If YES, What type? Living Will, Do not Resuscitate, Assignment of Healthcare, Power of Attorney, Assignment of Surrogate. \*\*\**This facility does not acknowledge advance directives and if an adverse event occurs during your treatment at this facility, we will initiate resuscitative and stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measure already begun will be ordered in accordance with your wishes, Advance Directive, or* *Healthcare Power of Attorney.*

I authorize Heart Care Centers of Florida and staff to release Protected Health Information to individuals listed above. I grant permission to the employees of HCCF to render care to myself and expedite the orders of the physician. I further authorize release of this information to other healthcare provider’s associated with my care**.**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



 **HEART CARE CENTERS OF FLORIDA**

 **Authorization to Release Health Information**

 **Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Covering the period of healthcare from (dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_**

**Information to be disclosed:**

**\_\_History and Physical \_\_Consultation Reports \_\_ Summary**

**\_\_Progress Notes \_\_ Physicians orders \_\_EKG**

**\_\_ Complete Health \_\_ Labs and X-rays \_\_ Medication records**

**\_\_Treatment \_\_Care Plan \_\_Other**

**If applicable, I also give permission for the following to be disclosed (please initial)**

**\_\_\_Acquired Immunodeficiency Syndrome (AIDS) or infected with Human Immunodeficiency Virus (HIV)**

**\_\_\_Behavioral Health Services/Psychiatric care**

**\_\_\_Treatment for Alcohol and or drug abuse**

 **Please release information to HEART CARE CENTERS OF FLORIDA**

3822 S. Washington Av 600 Palmetto St., Suite 1

Titusville, Florida 32780 New Smyrna Beach, Fl 32168

Ph: 321-636-6914 Ph: 386-423-3870

Fax: 321-636-6916 Fax: 386-424-3871

I understand that I have the right to revoke this information at any time. This authorization will expire in 90 days.

I understand that any disclosure of information carries with it potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If any questions about the disclosure of my health information, then contact the privacy officer at the number above.

Patients Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO TREAT - ACKNOWLEDGMENT OF BENEFITS**

**CONSENT FOR MEDICAL TREATMENT**

I/We voluntarily consent to medical treatment and diagnostic procedures provided by HEART CARE **CENTERS OF FLORIDA** and its associated physicians, clinicians and other personnel. I/We consent to the testing for infectious diseases such as, but not limited to AIDS, Hepatitis and drug testing if deemed advisable by the physician. I/We am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

**ASSIGNMENT OF INSURANCE BENEFITS**

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights to any insurance benefits or other funding to the physician and **HEART CARE CENTERS OF FLORIDA**. I/We understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefit. I/We understand that **HEART CARE CENTERS OF FLORIDA** can obtain my/our credit report for review in collection of this in the event that my/our account is placed with collection agency or attorney for collection or collected. I/We shall pay all collections fees and costs, including reasonable attorney fees for Medicare beneficiaries. I/We have provided all necessary information for proper assignment of Medicare benefits.

**“No Show” Policy**

As a courtesy to staff and patients, please call the office upon becoming aware of potential conflicts with your scheduled appointment time.

**PLEASE PROVIDE AT LEAST 24 HOUR NOTICE OF ANY CANCELLATION OR RESCHEDULING OF** **-** **APPOINTMENT**. This reserves the right to charge a $50.00 administrative fee for any non-emergent cancellation that is not made within 24 hours of your scheduled appointment.

**FORMS**

**There is a $20.00 fee for completion of disability forms, Life insurance, or Workmen’s Compensation forms. Payment shall be made at the time of the form being dropped off. Please allow 10 business days for forms completion. Forms cannot be completed prior to your office visit or surgery date. We understand the importance of the completion of your forms. Be certain to provide any and all necessary information to insure that your paperwork is properly accurately.**

I have read the above Consent to Treat, and Acknowledgement of Benefits. I have also read Heart Care Centers of Florida “No Show” Policy, and am aware that failure to show for scheduled appointment or provide at least 24 hours’ notice of will result in $50.00 fee.

Patient/Guarantor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Heart Care Centers of Florida**

 **PRIVACY NOTICE ACKNOWLEDGEMENT**

Purpose: This form is used to document (a) an individual’s acknowledgement of a receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgment, our good faith effort to obtain the acknowledgement.

 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of receipt of Privacy Practices Notice**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have received a Privacy Practices Notice from Heart Care Centers of Florida.

**By signing below I provide my permission for Heart Care Centers of Florida to disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices**.

(If you did not receive Privacy Notice, please check with receptionist.)

***For office Staff:***

*If not signed: (good faith effort to obtain acknowledgement of the receipt)*

*Describe reason individual would not sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Describe your good faith efforts to obtain the individual’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_