WCAC
WEST COAST ARRHYTHMIA CENTER

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NEW PATIENT INFORMATION

Patient Name: _____

Street Address: _____

City, State and Zip Code: _____

Out of State Address: _____

City, State and Zip Code: _____

Phone Number: _____ **Patient Email Address:** _____

Social Security Number: _____ **Date of Birth:** _____

Marital Status: Single _____ **Married** _____ **Divorced** _____ **Widowed** _____

Spouse Name: _____ **Spouse Date of Birth:** _____

Employer: _____ **Work Phone:** _____

Emergency Contact: _____

Emergency Contact Phone Number: _____ **Relationship:** _____

Primary Insurance: _____

Secondary Insurance: _____

Cardiologist: _____ **Primary Care Physician:** _____

Referring Physician: _____ **Reason for Referral:** _____

Pharmacy Name: _____ **Intersecting Streets:** _____

PATIENT HISTORY FORM

Have you experienced any of the following symptoms?

Yes	No		Yes	No	
☐	☐	Chest pain	☐	☐	Dizziness or lightheadedness
☐	☐	Shortness of breath	☐	☐	Passing out or nearly passing out
☐	☐	Palpitations	☐	☐	Painful legs when walking
☐	☐	Swelling in your feet or legs	☐	☐	Recent hospitalization (last 6 mo) where? _____

Cardiac Surgeries & Procedures:

- ☐ Cardiac Cath Year: _____
- ☐ Cardioversion Year: _____
- ☐ Coronary Angioplasty/Stent Year: _____
- ☐ Coronary Artery Bypass Year: _____
- ☐ EP Study Year: _____
- ☐ ICD Placement Year: _____
- ☐ Pacemaker Implant Year: _____
- ☐ RF Ablation Year: _____
- ☐ Heart Valve Repair/Replaced Year: _____
- ☐ Other: (List Below) Year: _____
- ☐ Stress Test Year: _____
- ☐ Echocardiogram Year: _____
- ☐ Sleep Study Year: _____
- ☐ Carotid Ultrasound Year: _____
- ☐ Holter Monitor Year: _____
- ☐ Event Recorder Year: _____

Other Surgeries & Procedures:

- ☐ Aneurysm Repair Year: _____
- ☐ Appendectomy Year: _____
- ☐ Back Surgery Year: _____
- ☐ Carotid Surgery Year: _____
- ☐ Cholecystectomy (gallbladder removed) Year: _____
- ☐ Gastric Bypass Year: _____
- ☐ Hysterectomy Year: _____
- ☐ Kidney Stone Treatment Year: _____
- ☐ Knee Surgery Year: _____
- ☐ Mastectomy Year: _____
- ☐ Nephrectomy (kidney removed) Year: _____
- ☐ Tonsillectomy Year: _____
- ☐ Thyroidectomy Year: _____
- ☐ Other: _____ Year: _____

Please list your current medications <u>including</u> over the counter supplements.

BRING ALL MEDICATION IN ORIGINAL CONTAINERS TO EVERY APPOINTMENT

Name	Dosage	Directions

ALLERGIES Do you have allergies drugs, food, seafood, latex, dye? Yes____ No____

Allergy to:	Reaction – rash, shortness of breath, hives, itching, etc.

Past Medical History: Have you been diagnosed with or treated for the following?

Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Blood Disease
☐	☐	Anemia	☐	☐	High Cholesterol
☐	☐	Aortic Aneurysm or Dissection	☐	☐	Hyperlipidemia
☐	☐	Arrhythmia	☐	☐	Hypertension
☐	☐	Asthma	☐	☐	Irregular Heart Beat
☐	☐	Blood Clots	☐	☐	Kidney Disease
☐	☐	COPD	☐	☐	Heart Attack (MI)
☐	☐	CVA	☐	☐	Liver Disease
☐	☐	Cancer (Including Skin) Date Dx: _____	☐	☐	Lung Disease
☐	☐	Cardiomyopathy	☐	☐	Other (Please Specify Below)
☐	☐	Circulation Problems	☐	☐	Pacemaker
☐	☐	Congenital Heart Disease	☐	☐	Peripheral Arterial Disease
☐	☐	Congestive Heart Failure	☐	☐	Pulmonary Embolism
☐	☐	Coronary Artery Disease	☐	☐	Sleep Disorder
☐	☐	Deep Vein Thrombosis	☐	☐	Stroke
☐	☐	Depression	☐	☐	Thyroid Problems
☐	☐	Diabetes (Type I or II)	☐	☐	Ulcers/Gastric Reflux
☐	☐	Glaucoma	☐	☐	Valvular Abnormalities
☐	☐	HIV	☐	☐	Warfarin Management

Other: _____

Social History:

Have you ever been a smoker? Yes ☐ No ☐ Current ☐ Former _____

How many years? _____ Average packs per day? _____ Year quit? _____

Do you consume alcohol? Yes ____ No ____ How often do you drink? _____ Illicit drugs: Yes____ No ____

Marital status: Married _____ Single _____ Divorced _____ Widow/Widower _____

Do you have any children? _____ How many? _____

Are you currently employed or retired? Employed _____ Retired _____ Other _____

(If employed / retired please specify occupation) Occupation: _____

Family History of Heart Disease: Yes____ No ____

Caffeine Intake: None____ Occasional ____ Moderate ____ Heavy ____

Exercise Level: None____ Occasional ____ Moderate ____ Heavy ____

Live alone or with others: Alone ☐ with others ☐

Advance directive: Yes____ No ____ Do you feel safe at home? Yes____ No ____

Deaf or difficulty hearing: Yes____ No ____ Blind or difficulty seeing: Yes____ No ____

Difficulty concentrating, remembering or making decisions: Yes____ No ____

Difficulty walking or climbing stairs: Yes____ No ____

Have any of your <u>immediate</u> family members had the following?

Yes	No		If yes, who / age?	Yes	No		If yes, who / age?
☐	☐	Heart Disease	_____	☐	☐	High blood pressure	_____
☐	☐	Heart Attack	_____	☐	☐	Diabetes	_____
☐	☐	Stroke or TIA	_____	☐	☐	Arrhythmias	_____
☐	☐	High Cholesterol	_____	☐	☐	Fainting	_____
☐	☐	Pacemaker/AICD	_____				

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by Interventional Cardiac Consultants, P.L.C. deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/insurance benefits be made either to me, or on my behalf, for any services furnished by Interventional Cardiac Consultants, P.L.C. I authorize any holder of medical information about me to be released to CMS/Insurance Carriers and its agents. Any information needed to determine these benefits or benefits related to services may be released.

I hereby authorize Interventional Cardiac Consultants, P.L.C. to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for elated services. I hereby authorize (assign) my insurance carrier(s)/Medicare to make payment directly to Interventional Cardiac Consultants, P.L.C. for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature: _____ Date: _____

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with:

( ) Spouse: _____

( ) Children: _____

( ) Other: _____

In case of emergency, please list the family members or significant others, if any, whom we may inform about your medical condition.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

PRIVACY NOTICE

I have received a copy of Interventional Cardiac Consultants, P.L.C. office's privacy notice

Signature: _____ Date: _____

Patient Name (print): _____ Witness: _____

Interventional Cardiac Consultants, P.L.C.

Carlos J. Bayron, M.D., F.A.C.C. • Luis Annoni-Suau, M.D., F.A.C.C. • Rudy E. Kunhardt, M.D.
• Raul A. Jimenez, M.D., F.A.C.C. • Abdur Rahim, M.D, F.A.C.C

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: March 26, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at (727) 842-9486

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in

order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.
To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in should with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require will require a separate written authorization.

• Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.

• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system as listed below:

Athena Health, Inc 311 Arsenal Street Watertown, MA 02472 Phone: 800-981-5084 Fax: 617-402-1099

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Debbie Brick R.N at (727) 842-9486 opt 2 .

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W.,
Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

West Coast Arrhythmia Center

RELEASE OF CONFIDENTIAL INFORMATION

I, _____

SS# _____ Date of Birth: _____

Address: _____ Phone: _____

Authorize (Requested): _____

The information will be used for the following purpose:

- ☐ Continued medical care
- ☐ Legal follow- up
- ☐ Personal information
- ☐ Insurance
- ☐ Disability
- ☐ Other

To release information from my medical records requested medical information, including:

- ☐ Information of psychological, psychiatric, alcohol or drug related nature
- ☐ HIV antibody test results and AIDS records
- ☐ Office note; lab work; testing and x-rays
- ☐ Other: _____

To (Requestor):

West Coast Arrhythmia Center
14100 Fivay Road Suite 310
Hudson, Florida 34667
Phone- (727) 862-3202 # 1
Fax- (866) 345-3480

I understand that this consent shall be valid for a period of one (1) year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released upon this authorization. No individual has coerced me into signing this authorization; I am providing this authorization under my own free will.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42 CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise requested.

_____
Patient's Signature

_____
Patient Representative's Signature

_____
Date of Signature

_____
Relationship to Patient

_____
Witness

Cancellation policy

We understand that scheduling conflicts and last-minute changes are necessary at times, but we respectfully ask for a 24 hours' notice for in office visits. Appointments cancelled within 24 hours of the scheduled appointment time will result in a cancellation fee of $25 charged to your account.

Surgical appointments cancelled within 5 business days will result in a cancellation fee of $150 to be charged to your account.

By signing this form, you acknowledge our policy on cancellations.

Patient Signature: _____ **Date:** _____