

COMPLETE CARDIOLOGY CARE & ATLANTIC CARDIOVASCULAR

ALL ITEMS MUST BE COMPLETED. PLEASE PRESENT YOUR INSURANCE CARDS TO THE FRONT DESK

LAST NAME		FIRST NAME		GENDER: MALE FEMALE		BIRTHDATE / /		AGE	
MARITAL STATUS S M WID DIV SEP		SOC. SECURITY #		HOME TELEPHONE		CELL PHONE #			
MAILING ADDRESS				CITY		STATE		ZIP	
HOME "RESIDING" ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)				CITY		STATE		ZIP	
EMPLOYER;						EMPLOYER PHONE #			
EMAIL ADDRESS			EMERGENCY NAME AND PHONE NUMBER OF FRIEND OR RELATIVE:						
ARE YOU 'ACTIVE' MILITARY YES NO		TO COMPLY WITH FEDERAL REGULATIONS, WE ARE REQUIRED TO ASK YOU TO FILL OUT THE FOLLOWING: RACE: <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN/ALASKAN <input type="checkbox"/> ASIAN <input type="checkbox"/> NAT'L HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> ETHNICITY: HISPANIC OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PREFER NOT TO DISCLOSE							

1) PRIMARY INSURANCE COMPANY NAME		INSURANCE POLICY ID #		
INSURANCE GROUP #	NAME OF SUBSCRIBER		SUBSCRIBER'S BIRTH DATE	RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DAUGHTER SON
2) SECOND INSURANCE COMPANY NAME		INSURANCE POLICY ID #		
INSURANCE GROUP #	NAME OF SUBSCRIBER		SUBSCRIBER'S BIRTH DATE	RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DAUGHTER SON

PRIMARY CARE PHYSICIAN:		PHYSICIAN TEL #:	
REFERRING PHYSICIAN:		PHYSICIAN TEL #:	
I HEREBY GRANT PERMISSION TO COMPLETE CARDIOLOGY CARE TO ACCESS MY FULL MEDICATION HISTORY: <input type="checkbox"/> YES <input type="checkbox"/> NO			
LOCAL PHARMACY:	ADDRESS:		PHONE:

I ACKNOWLEDGE RECEIPT, REVIEW AND AGREEMENT OF THE FOLLOWING DOCUMENTS: 1) PATIENT FINANCIAL FORM, 2) NOTICE OF PRIVACY PRACTICES.

I HEREBY GIVE MY CONSENT FOR COMPLETE CARDIOLOGY CARE & ATLANTIC CARDIO VASCULAR TO RELEASE PHI ABOUT ME TO THE FOLLOWING PERSON(S); (PLEASE SPECIFY THE RELATIONSHIP, E.G., SPOUSE, IMMEDIATE FAMILY, CAREGIVER, ETC):

PLEASE INCLUDE BOTH NAME AND PHONE NUMBER

1) _____ 2) _____

3) _____ 4) _____

HEALTH HISTORY QUESTIONNAIRE

REFERRING DOCTOR: PRIMARY CARE:		PHARMACY NAME & PHONE #:	
LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED			
SURGERIES			
Year	Reason	Hospital	
OTHER HOSPITALIZATIONS			
Year	Reason	Hospital	
ALLERGIES TO MEDICATIONS			
Name the Drug		Reaction You Had	
Cardiac History	<input type="checkbox"/> Catheterization <input type="checkbox"/> Angioplasty/Stents <input type="checkbox"/> Bypass Surgery <input type="checkbox"/> Heart Attack <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Valve Replacement <input type="checkbox"/> Ablation <input type="checkbox"/> Pacemaker or Defibrillator <input type="checkbox"/> History of Atrial Fibrillation		
	<input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Renal Disease <input type="checkbox"/> COPD <input type="checkbox"/> Asthma <input type="checkbox"/> Heart palpitations or flutter <input type="checkbox"/> Irregular Heart Beat		
	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Sharp <input type="checkbox"/> Fullness <input type="checkbox"/> Heaviness If yes to any, How long does it last? _____ What relieves it? _____		
	<input type="checkbox"/> Shortness of breath with chest pain <input type="checkbox"/> Burping with chest pain <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Passed out, if so when? _____		
Vascular History	Do you experience any of the following in your legs? <input type="checkbox"/> Aching/pain <input type="checkbox"/> Heaviness <input type="checkbox"/> Tiredness/fatigue <input type="checkbox"/> Itching/burning <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Restless legs <input type="checkbox"/> Throbbing		

PATIENT CONSENT FOR RELEASE AND USE OF PROTECTED HEALTH INFORMATION

I, _____, hereby give my consent to Complete Cardiology Care to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record. Our practice originates and maintains paper and/or electronic health records describing my health history, symptoms, examination and test results, diagnoses, treatment, including HIV/AIDS, mental health or substance abuse and any plans for future care or treatment.

I understand that if I do not sign this form, Complete Cardiology Care may refuse to treat or care for me.

I understand that I have a right to review the practices Notice of Privacy Practices (the "Notice") for a more complete description of the uses and disclosures prior to signing the consent. The Notice provides detailed information about how we may use and disclose your confidential information.

I understand that Complete Cardiology Care has reserved the right to change the privacy practices that are described in this Notice. I also understand that if Complete Cardiology Care makes changes in this notice, their office will provide me a copy of the revised Notice in accordance with the procedures set forth in the Notice itself. I understand that I have the right to request that Complete Cardiology Care restrict how my health information is used or disclosed, but that Complete Cardiology Care is not required to agree to my request. However, if Complete Cardiology Care does agree to my request, the restriction will be binding on Complete Cardiology Care. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by sending written notice of my desire to do so to Complete Cardiology Care. I also understand that if I revoke this consent such revocation will not be effective to the extent that Complete Cardiology Care has already relied on it to use or disclose my health information.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL / PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

**Effective Date of this Notice Under HIPAA regulations in effect
on 01/01/2023**

Contact Person: M. Albone

Phone Number: 386-672-1023 Press extension for Billing

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practices **NOTICE OF PRIVACY PRACTICES**, I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified or changed in any way."

Signature: _____ Date: _____

Patient refused to sign _____

Patient was unable to sign because: _____

COMPLETE CARDIOLOGY CARE & ATLANTIC CARDIOVASCULAR FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, copayments and deductibles for participating insurance companies. We accept cash, personal checks, VISA, and MasterCard and Discover. There is a service charge for returned checks. **Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.**

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. If you need assistance or have questions, please contact **The Billing Office between 9:00 a.m. and 3:00 p.m., Monday through Friday at 386-449-7829.**

REFUNDS

Patient/guarantor credits in amounts less than \$20.00 will be retained on account to be credited toward future balances unless a written request for refund is received.

MANAGED CARE

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from your Primary Care Physician. We will request the referral but that is not a guarantee your physician will authorize your visit.

Signature: _____ Date: _____

APPOINTMENT CANCELLATION POLICY

For Office Appointments

A cancellation made with **less than a 24 hour** notice significantly limits our ability to make the appointment available for another patient in need. Therefore, Complete Cardiology Care has instituted an appointment cancellation policy.

Patients are required to provide our office a 24-hour notice in the event that you need to cancel or reschedule your appointment. This will allow us the opportunity to provide care to another patient.

Appointment cancellations must be left with the office **NOT THE ON CALL SERVICE**.

1. The “No-Show”, “No-Call” or missed appointment without proper 24-hour notification may be assessed a **\$40 fee**.
2. This fee is not billable to your insurance
3. If you are 20 minutes or more late to your appointment, the appointment may be cancelled and rescheduled. The applicable fee may be assessed.
4. **As a courtesy**, we make reminder calls for appointments two days in advance. Please note, if a reminder call or message is not received, the cancellation/no-show policy remains in effect.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PROCEDURE CANCELLATION POLICY

For Procedures

A cancellation made with **less than a 72 hour** notice significantly limits our ability to schedule a procedure for another patient in need. Therefore, Complete Cardiology Care has instituted a procedure cancellation policy.

Patients are required to provide our office a 72-hour notice in the event that you need to cancel or reschedule your procedure. This will allow us the opportunity to provide care to another patient. Appointment cancellations must be left with the office **NOT THE ON CALL SERVICE**.

1. The "No-Show", "No-Call" or missed procedure without proper 72-hour notification may be assessed a **\$100 fee**.
2. This fee is not billable to your insurance

I have read and understand the Procedure Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____



Complete Cardiology Care

Board Certified Cardiology & Electrophysiology

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I do hereby consent and authorize Complete Cardiology Care to obtain my medical records for continuation of medical care.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

RECORDS TO BE SENT FROM:

Physician/Facility: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

RECORDS TO BE SENT TO:

Physician/Facility: Complete Cardiology Care, P.A.

Address: 1240 West Granada Boulevard, 2nd Floor, Ormond Beach, FL 32174

Phone: 386.672.1023 **Fax:** 386.263.2996 **Email:** info@completecardiologycare.com

PLEASE SEND RECORDS VIA: ☐ Mail ☐ Fax ☐ Email

PLEASE SEND THE FOLLOWING MEDICAL RECORDS:

<input type="checkbox"/> Office Notes Past Year	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Hospital Records	<input type="checkbox"/> ER Records	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Pacer/ICD/Loop Reports	<input type="checkbox"/> Echo/Carotid/Doppler	<input type="checkbox"/> Most Recent EKG
<input type="checkbox"/> Holter/Monitor Reports	<input type="checkbox"/> Stress Tests	

☐ Other: _____
