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	EMPOLOYER PHONE #

EMAIL ADDRESS	EMERGENCY NAME AND PHONE NUMBER OF FRIEND OR RELATIVE:

ARE YOU 'ACTIVE" MILITARY ☐ YES ☐ NO	TO COMPLY WITH FEDERAL REGUULATIONS, WE ARE REQUIRED TO ASK YOU TO FILL OUT THE FOLLOWING: RACE: ☐ WHITE ☐ HISPANIC/LATINO ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKAN ☐ ASIAN ☐ NAT'L HAWAIIAN/PACIFIC ISLANDER ☐ OHTER ETHNICITY:_____ ☐ 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: ☐ YES ☐ NO

LOCAL PHARMACY:	ADDRESS:	PHONE:

I HEREBY GIVE MY CONSENT FOR COMPLETE CARDIOLOGY CARE & ATLANTIC CARDIOVASCULAR TO RELEASE PHI ABOUT ME TO THE FOLLOWING PERSON(S); (PLEASE SPECIFY THE RELATIONSHIP, E.G., SPOUSE, IMMEDIASTE 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	□ Catheterization □ Angioplasty/Stents □ Bypass Surgery □ Heart Attack □ Low Blood Pressure □ High Blood Pressure □Valve Replacement □ Ablation □ Pacemaker or Defibrillator □ History of Atrial Fibrillation
	□ Diabetes □ High Cholesterol □ Renal Disease □ COPD □ Asthma □ Heart palpitations or flutter □Irregular Heart Beat
	□ Chest Pain □ Sharp □ Fullness □ Heaviness If yes to any, how long does it last? What relieves it?
	☐ Shortness of breath with chest pain ☐ Burping with chest pain ☐ Dizzy spells ☐ Passed out, if so when?
Vascular History	**Do you experience any of the following in your legs?** **□Aching/pain □Heaviness □Tiredness/fatigue □Itching/burning** **□Swollen Ankles □Leg Cramps □Restless legs □Throbbing**

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	□ Sedentary (No exercise)					
	□ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	□ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	□ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Caffeine	□ None	□ Coffee____c/day	□ Tea_____c/day	□ Cola_____c/day		
Alcohol	Do you drink alcohol?				□ Yes	□ No
	If yes, what kind?		How many drinks per week?			
Tobacco	Do you use tobacco?				□ Yes	□ No
	□ Cigarettes ____ pks./day		□ Chew ___/day	□ Pipe___/day	□ Cigars___/day	
	#of years____	Year quit_____				
Vape	Do you Vape?	□ Yes □ No				
Drugs	Do you currently use recreational or street drugs? (Marijuana, etc.)				□ Yes	□ No
	Have you ever given yourself street drugs with a needle?				□ Yes	□ No
Personal Safety	Do you live alone?				□ Yes	□ No
	Do you have frequent falls?				□ Yes	□ No
	Do you have vision loss?				□ Yes	□ No
	Do you have hearing loss?				□ Yes	□ No
	Do you have an Advance Directive or Living Will?				□ Yes	□ No

FAMILY HEALTH HISTORY					
	AGE	HEALTH PROBLEMS		AGE	HEALTH PROBLEMS
FATHER CIRCLE: **ALIVE OR DECEASED**			***Children***	□M □ F	
MOTHER CIRCLE: **ALIVE OR DECEASED**				□M □ F	
Sibling INDICATE: **ALIVE OR DECEASED**	□M □ F			□M □ F	
	□ M □ F			□M □ F	
	□ M □ F		**G'MOTHER** *Maternal*		
	□ M □ F		**G'FATHER** *Maternal*		
	□ M □ F		**G'MOTHER** *Paternal*		
	□ M □ F		**G'FATHER** *Paternal*		

MEDICATIONS		
PLEASE LIST ALL CURRENT MEDICATIONS, DOSES, AND FREQUENCIES		

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 to this notice, their office will provide me with 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.

Patient Name:_____ Date of Birth:_____

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.
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 ensure 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 01/01/2026
Contact Person: Marci
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."

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

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 for being 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 that your physician will authorize your visit.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

PATIENT RESPONSIBILITY AGREEMENT

To ensure a smooth and transparent billing process, we kindly request your acknowledgment and understanding of the following terms:

INSURANCE INFORMATION

It is your responsibility to present your current and valid insurance card(s) at the time of service. This information is necessary for us to process claims with your insurance provider.

FINANCIAL RESPONSIBILITY

If you fail to provide your current insurance card(s) on the day of your visit, you acknowledge and accept that you may be held financially responsible for the full cost of the services rendered during your visit. This includes, but is not limited to, consultations, procedures, diagnostic tests, and treatments.

INSURANCE VERIFICATION

While we strive to assist with verifying your insurance coverage, it is ultimately your responsibility to ensure your insurance details are accurate and up to date.

PAYMENT TERMS

Payment for services may be required at the time of your visit if insurance information is not provided. If insurance details are submitted after the date of service, you may seek reimbursement directly from your insurance company.

By signing below, you acknowledge that you have read, understood, and agree to the terms outlined in this Patient Responsibility Agreement.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

APPOINTMENT CANCELLATION POLICY

For Office Appointments

A cancellation made with **less than 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 with 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 for 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 with 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 for 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 **$500 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:_____

FORM PROCESSING FEE

This letter is to inform you that our practice will charge a fee of $35 for completing any administrative forms, including but not limited to insurance forms, disability forms, FMLA, school forms, or any other non-medical documentation that requires physician review and signature. Please allow 5-7 business days for processing as these forms are completed when providers are not seeing patients.

Reason for the Charge:

- The time and expertise necessary to accurately complete these forms can significantly impact our ability to see other patients, meaning they cannot be completed during your scheduled appointment.
- Thorough review of your medical records and clinical information is often required to complete forms accurately.

What to Do:

- If you need forms completed, please outline any specific requests or requirements for the form in order to reduce time needed to complete the form and avoid the need for revisions; subsequent form completions or revisions will be subject to an additional $35 fee
- We are happy to discuss any concerns you may have about this policy.

Please note that this charge is separate from your standard office visit fee.

Thank you for your understanding.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

Complete Cardiology Care
Board Certified Cardiology & Electrophysiology

1240 W. Granada Blvd. 2nd Floor, Ormond Beach, FL 32174 | 4420 S Hopkins Ave., Titusville, FL 32780 | www.completecardiologycare.com
Ormond Beach - (386) 672-1023 | Titusville - (321) 265-4629 | Fax - (386) 263-2996 | info@completecardiologycare.com

H. James Wang, MD, FACC, FHRS
Ajit Janardhan, MD, FACC, FHRS
Florentino Lupercio-Lopez, MD, FACC, FHRS
Eric Lo, MD, FACC, FCRP
Ginger Riddle, MMS, PA-C
Arsheema Aming-Abdurahman, APRN, FNP-BC
Paul Bigenho, APRN, FNP-BC

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

☐ 860 Century Medical Dr, Titusville, FL 32796

Phone: 386.672.1023 / 321.265.4629 **Fax:** 386.263.2996 **Email:** info@completecardiologycare.com

PLEASE SEND RECORDS VIA: ☐ Mail ☐ Fax ☐ Email

PLEASE SEND THE FOLLOWING MEDICAL RECORDS:

☐ Office Notes Past Year	☐ Radiology Reports	☐ Lab Reports
☐ Hospital Records	☐ ER Records	☐ Operative Reports
☐ Pacer/ICD/Loop Reports	☐ Echo/Carotid/Doppler	☐ Most Recent EKG
☐ Holter/Monitor Reports	☐ Stress Tests	

☐ Other:_____