

COMPLETE CARDIOLOGY CARE & ATLANTIC CARDIOVASCULAR

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

LAST NAME		FIRST NAME		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		BIRTHDATE / /		AGE	
MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> WID <input type="checkbox"/> DIV <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> 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"/> HISPANIC/LATINO <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"/> OTHER ETHNICITY: _____ <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: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SON			
2) SECOND INSURANCE COMPANY NAME				INSURANCE POLICY ID #					
INSURANCE GROUP #		NAME OF SUBSCRIBER		SUBSCRIBER'S BIRTH DATE		RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> 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 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, IMMEDIATE FAMILY, CAREGIVER, ETC):

*****PLEASE INCLUDE BOTH NAME AND PHONE NUMBER*****

1) _____ 2) _____

3) _____ 4) _____

HEALTH HISTORY QUESTIONNAIRE

REFERRING DOCTOR:	PHARMACY NAME & PHONE #:
PRIMARY CARE:	

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

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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

HEALTH HABITS AND PERSONAL SAFETY

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee ___c/day	<input type="checkbox"/> Tea ___c/day <input type="checkbox"/> Cola ___c/day
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		How many drinks per week?
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes ___ pks./day	<input type="checkbox"/> Chew ___/day	<input type="checkbox"/> Pipe ___/day <input type="checkbox"/> Cigars ___/day
	#of years ___	Year quit ___	
Vape	Do you Vape?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Drugs	Do you currently use recreational or street drugs? (Marijuana, etc.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?		<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	HEALTH PROBLEMS		AGE	HEALTH PROBLEMS
FATHER CIRCLE: ALIVE OR DECEASED			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
MOTHER CIRCLE: ALIVE OR DECEASED				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling INDICATE: ALIVE OR DECEASED	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		G'MOTHER <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		G'FATHER <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		G'MOTHER <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		G'FATHER <i>Paternal</i>		

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: _____

TERMS AND CONDITIONS

Scheduling and Payment reminders

By opting in to our automated communications, you agree to the following terms and conditions regarding our text messaging system. We utilize these transmissions for the purpose of appointment scheduling, clinical reminders, and payment notifications. You acknowledge that message and data rates may apply depending on your cellular provider and service plan.

Your consent to receive these messages is not a condition of receiving medical treatment. You may revoke this consent at any time; simply reply STOP to opt out of future text communications. For additional information or assistance regarding the frequency or nature of these messages, reply HELP for help. For further technical or account support, please contact (386) 672-1023 for support.

Our office reserves the right to modify these terms or terminate the messaging service at any time without prior notice. Please ensure that the mobile number provided is accurate and that you are the primary account holder for the device to ensure the privacy of your protected health information. By signing this document you agree to the terms and conditions as outlined and consent to receive text messages as outlined above

SMS COMMUNICATION CONSENT

I consent to receive SMS text messages from Complete Cardiology Care for appointment reminders, billing notifications, and healthcare-related communications.

Message frequency varies. Message and data rates may apply.
Reply STOP to opt out. Reply HELP for help.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PRIVACY POLICY

Effective Date: March 13, 2026

Complete Cardiology Care, LLC ("Complete Cardiology Care," "we," "our," or "us") respects your privacy and is committed to protecting your personal information. This Privacy Policy explains how we collect, use, and safeguard information when you interact with our services, website, and communications. We may collect personal information such as your name, phone number, email address, and medical practice or patient-related information when you contact our office, register for services, or submit forms through our website. This information is used to provide medical services, communicate with patients, improve operational efficiency, support billing, and comply with legal obligations.

SMS / Text Messaging Disclosure

Complete Cardiology Care may use SMS messaging to communicate with patients, clients, and healthcare partners regarding operational matters, including appointment reminders, service updates, administrative notifications, and billing communications. SMS messaging will only be sent to individuals who have provided express prior consent. Users opt in by providing written or verbal authorization through office intake forms, service registration, or direct communication, which is then documented in the patient's chart. Please note that message frequency varies based on your interactions. Message and data rates may apply. Opt-in is not a condition of purchase or a requirement to receive medical treatment.

Your Rights: Opt-Out and Help

You may cancel the SMS service at any time. To stop receiving messages, text "STOP" to any message you receive from us. After you send the SMS message "STOP" to us, we will send you an SMS message to confirm that you have been unsubscribed. After this, you will no longer receive SMS messages from us. If you want to join again, just sign up as you did the first time and we will start sending SMS messages to you again. For assistance or more information, text "HELP" to any message or contact our office directly at (386) 672-1023.

Data Security and SMS Privacy

We implement reasonable administrative, technical, and physical safeguards to protect personal information from unauthorized access, consistent with HIPAA where applicable. SMS Data Protection: Notwithstanding any other section of this policy, phone numbers collected for the purpose of SMS communication, and the consent associated with them, will not be shared, sold, or rented to third parties or affiliates for marketing or promotional purposes. We may use trusted service providers to assist with technology infrastructure; however, these providers are contractually obligated to protect your confidential information.

Policy Updates and Contact

We may update this Privacy Policy periodically to reflect changes in our practices or regulatory requirements. Updated policies will be posted on this page with the revised effective date. If you have questions regarding this Privacy Policy or our data practices, please contact Complete Cardiology Care, LLC at (386) 672-1023.

By signing this form you agree to the following privacy policy and consent to receive SMS/Text messages as outlined above.

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: _____

