PATIENT INFORMATION:

NAME _____ DATE _____

HOME ADDRESS _____ HOME PHONE _____

CITY, STATE, ZIP _____ CELL PHONE _____

SEX _____ AGE _____ DATE OF BIRTH _____ MARITAL STATUS _____

DRIVER'S LICENSE _____ SOCIAL SECURITY # _____

EMPLOYER'S NAME AND ADDRESS _____

EMPLOYER'S PHONE NUMBER _____ OCCUPATION _____

PRIMARY CARE PHYSICIAN_____ RACE: WHITE BLACK HISPANIC ASIAN OTHER

SPOUSE'S NAME _____ SPOUSE'S CELL PHONE _____

SPOUSE'S EMPLOYER _____ SPOUSE'S EMPLOYER # _____

OUT OF STATE ADDRESS _____

OUT OF STATE PHONE NUMBER _____

EMERGENCY CONTACT:

NAME _____RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER _____

REFERRED BY:

Internet____ Radio _____ Friend _____ Physician _____ Other _____

INSURANCE INFORMATION (PROVIDE COPY OF ALL CARDS)

PRIMARY CARRIER _____ SECONDARY CARRIER _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO LAKEWOOD CARDIOVASCULAR. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO LAKEWOOD CARDIOVASCULAR, MY INSURANCE CARRIER, OTHER TREATING PHYSICIANS, MY ATTORNEY, IN REPONSE TO A SUBPOENA DUCES TETUM OR TO MY REPRESENTATIVE.

SIGNATURE _____ DATE _____

NEW PATIENT MEDICAL AND FAMILY HISTORY

Patient's full legal name: _____ Social Security #: _____

Are you allergic to any medications or foods: _____ YES _____ No
If Yes, please list: _____

Please list ALL of the medications that you are currently taking:

Name: _____Strength: _____How often taken:_____
Name: _____Strength: _____How often taken:_____
Name: _____Strength: _____How often taken:_____
Name: _____Strength: _____How often taken:_____
Name: _____Strength: _____How often taken:_____

Please list ALL of your surgical procedures:

Procedure: _____Year: _____ Procedure: _____ Year: _____

Procedure: _____ Year: _____Procedure: _____ Year: _____

If you have experienced any of the below, Please CIRCLE it:

Anemia
Gout
Stroke
Breathing Difficulties
Heart Palpitations
Heart Murmur
Abnormal EKG
Rheumatic fever
High Blood Pressure
Angina
Heart Attack
Overweight
Hiatal Hernia
Arthritis
Gallbladder problems
Thyroid Problems
Kidney Problems
Ulcers
Bowel Problems
Psychiatric Problems
Liver Problems
Other- please specify: _____

Have you ever had:

Diabetes
If yes, controlled by_____
High Cholesterol
If yes, count & when_____
Stress Test
If yes, when & where_____
Nuclear Stress Test
If yes, when & where_____
Cardiac Catheterization
If yes, when & where_____
PTCA (Angioplasty)
If yes, when & where_____
Cardiac Bipass Surgery
If yes, when & where_____
Pacemaker
If yes, when & where_____
Heart Valve Replacement
If yes, when & where_____
Defibrillator Implant
If yes, when & where_____

Do you CURRENTLY use tobacco? _____ YES _____ NO
If yes, please circle one or more: cigars cigarettes pipe chewing tobacco

Have you EVER used tobacco? _____ YES _____ NO
If yes, please circle one or more: cigars cigarettes pipe chewing tobacco
Please estimate your daily consumption of alcohol:
_____

FAMILY HISTORY

Is your father living? _____ YES _____ NO His age, or age at death: _____
Cause of death: _____
Is your mother living? _____ YES _____ NO Her age, or age at death: _____
Cause of death: _____
How many brothers do you have? _____ Number living:_____ Number deceased: _____
Ages and cause(s) of death: _____
How many sisters do you have? _____ Number living:_____ Number deceased: _____
Ages and causes(s) of death: _____
How many children do you have? _____ Ages: _____
Any health problems? _____ YES _____ NO If yes, of what nature? _____
How many grandchildren do you have? _____

If ANY of the following illnesses run in your family, please CIRCLE:

Diabetes Which family member? _____
Stroke Which family member? _____
Hypertension Which family member? _____
Heart Disease Which family Member? _____

IS THERE ANYTHING ADDITIONAL THAT WE SHOULD KNOW ABOUT YOUR HEALTH OR HISTORICAL BACKGROUND?
_____YES _____ NO
If yes, please explain:

EMERGENCY CONTACT PERSON: _____
PHONE # FOR EMERGENCY CONTACT: _____

Patient's PRINTED name (or legal guardian)

Patient or Legal Guardian Signature Date

LAKEWOOD CARDIOVASCULAR CONSULTANTS, PA

DISCLOSURE and DISCUSSION of PROTECTED HEALTH INFORMATION and EMERGENCY CONTACT

According to **HIPAA** regulations, we must obtain your permission to leave information on voice mails, answering machines or with other persons or to discuss or disclose any medical information with persons other than you.

I authorize the facility to communicate with the following individuals regarding my condition, diagnosis, treatment, appointments (past and future) and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I authorize the facility to leave voice mail or answering machine messages regarding health related concerns at my home or cell phone number. Yes_____ No_____

Emergency Contact: _____ **Relationship**: _____

Phone Number: _____ - _____- _____.

CONSENT FOR TREATMENT

I hereby consent and authorize **LAKEWOOD CARDIOVASCULAR CONSULTANTS** to perform medical examinations and provide routine medical care. This may include diagnostic and laboratory procedures and tests, medication administration and other routine care for which a specific consent form will not be signed by me. I understand that certain procedures will require a specific informed consent, and that the facility will provide me with information and forms prior to such procedures. I also authorize the facility to search for and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out or make changes to this form, at any time, by notifying the facility.

Name: _____ Signature: _____

Patient Representative (If patient unable to sign):

_____ Signature: _____

Date: _____

Lakewood Cardiovascular Consultants, PA
Financial Policy

Lakewood Cardiovascular Consultants, PA, believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, credit card or debit card. Payment will include any unmet deducible, co-insurance, co-pay amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. Please be sure to bring your insurance cards with you at each appointment. We do also ask for a copy of a photo ID or license. Please ask about our fees before the visit.

2. **INSURANCE –** We are participating providers with multiple insurance plans but not 100% of all insurance plans. We will file all of these insurance claims on your behalf. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

   If our doctor is not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan that we do not have a prior arrangement with, we may still prepare and send the claim on your behalf on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for your care are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for lack of one.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. **REFUNDS** are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full. We will not seek amounts less than $5.00, and will not refund less than $5.00 unless requested.

4. **RETURNED CHECKS** will incur a $25.00 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.

5. **ACCOUNTING PRINCIPLES –** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. **COMPLETING INSURANCE FORMS, COPYING MEDICAL RECORDS,** ETC. Requires office staff time and time away from patient care for our doctors. We may require pre-payment for completing forms, copying medical records, or for extra transcription by the doctors. The charge is determined by the length and complexity of the form or letter. We do require that you complete the personal sections of the form before presenting to our office.

7. If you have questions in regard to any of your billing statements our staff is available to assist you.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or Responsible Party, if minor) Date

Please print the name of the patient

LAKEWOOD CARDIOVASCULAR CONSULTANTS, PA
NO SHOW/CANCELLATION POLICY

We understand that, sometimes emergencies arise, and that you may need to cancel or reschedule your appointment. If you are unable to keep your appointment, please call us as soon as possible (**WITH AT LEAST 48 HR NOTICE**). You can cancel appointments by calling our office at **941-907-1113.** To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important that patients arrive on time to their appointments. As a courtesy, an appointment reminder call is made (or attempted) two (2) business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please provide 48-hr notice if you need to cancel your appointment. There are numerous patients waiting to see the providers at Lakewood Cardiovascular Consultants and whenever possible, we like to fill empty spaces in order to shorten the waiting period for our patients.
2. If less than a 48-hour cancellation is given, this will be documented as your first "No-Show" appointment.
3. After the first "No-Show", you will receive a phone call notifying you that you did not keep your appointment. Our office staff will assist you in rescheduling your appointment.
4. If you have 2 consecutive "No-Show or Cancelled" appointments within one year time period, you will be charged a $50. fee for each missed appointment.

I have read and understand Lakewood Cardiovascular Consultants' "No-Show/ Cancelled" Appointment Policy and understand my responsibility to plan appointments accordingly and to notify their office timely if I have any difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name & DOB Patient Signature Date

Staff Signature: _____