Leesburg Office
803 E Dixie Ave, Leesburg, FL 34748

Lady Lake Office
809 CR 466 Suite 101-C, Lady Lake, FL 32159

Office: 352-530-2256 | Fax: 352-315-0069
www.cardiacsspecialtyinstitute.com

ANNUAL UPDATE

Patient's Name: _____ Male ☐ Female ☐

Home Address:

_____
_____
_____

Northern Address:

_____
_____
_____

Home Phone:_____ Cell phone:_____
Date of Birth: _____
eMail Address: _____

Marital Status (Circle): Married Divorced Single Widowed

Emergency Contact:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Referring Physician:
Physician Name: _____ Phone: _____
Reason for Referral: _____

Primary Care Physician:
Physician Name: _____ Phone: _____

Primary Insurance:
Insurance Company: _____ Phone: _____
Subscriber Number: _____ Group Number: _____

Secondary Insurance:
Insurance Company: _____ Phone: _____
Subscriber Number: _____ Group Number: _____

Pharmacy of Choice: _____
Address: _____ Phone: _____

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Medical Release Form

Patient Name: _____ Date of Birth: _____ SS #: _____

I hereby authorize Cardiac Specialty Institute to obtain my medical records from:

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ State: ____ Zip Code: _____ City: _____ State: ____ Zip Code: _____

Phone: (___) _____ Phone: (___) _____

Fax: (___) _____ Fax: (___) _____

Information to be Disclosed: _____ Complete Chart Records - From:_____ To:_____

Purpose of Disclosure: ___ Continuing Care ___ Legal ___ Payment of Claim ___ School ___ Personal Use

Other: _____

_____

I specifically authorize the release of information relating to (For consent, initial each one.):
_____

____ Substance House ___ HIV Related Information ___Behavioral Health ___Communicable Disease

Acknowledgement of Understanding:

1. I understand the expiration date of authorization is ONE year.
2. I understand that I may revoke this authorization at any time in writing. It will be effective on the date notified, except to the extent action that has already been taken.
3. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal privacy regulation.
4. I understand, by authorizing the use of disclosure of information, there will be no conditions placed on my healthcare or payment for my healthcare.
5. I understand that I have a right to receive a copy of this form after I have signed it.
6. understand that, in compliance with Flroida law, I may be required to pay a fee for the retrieval and photocopying of records and/or supervising inspection of those medical records.

Patient/Guardian Signature: _____ Date: ____/____/___

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HIPPA Patient Questionnaire

1. Please list the family members or other person(s), if any, when we may inform you about your condition and your diagnsosis (including treatment, payment, and health care options):

   Name: _____

   Name: _____

   Name: _____

2. Please list the family members or other person(s), if any, whom we may inform about your condition **ONLY IN AN EMERGENCY**:

   Name: _____

   Name: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home (Confidential Communications):

   Street Address: _____ City: _____ State: ___ Zip: _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**:

   _____ YES _____ NO

I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

Patient Signature: _____ Date: _____

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Billing and Insurance Procedure

1. I request that payment of authorized Medicare/Other Insurance Company benefits be made on my behalf to Cardiac Specialty Institute for services rendered from physicians or associates of Cardiac Specialty Institute.
   ( ) Initials

2. I authorize Cardiac Specialty Institute to release any medical information concerning me to my insurance company or its agents that is necessary to determine benefits or the benefits related to the payable services. I am aware that I am responsible for any deductables, co-insurance, and non-covered services. I understand this applies to all Medicare and commercial Insurance companies. **( ) Initials**

3. I understand that payment is due at the time servies are rendered. All co-pays and deductibles will be collected. **( ) Initials**

4. Cardiac Specialty Institute will file a claim to the patient's insurance company. If the insurance company does not respond to the claim within 60 days from the date of billing, then the balance will become the patient's responsibility. The patient will receive a statement, and payment is due upon receipt. If payment has not been made within 30 days, further action will be taken. If the patient's deductible has not been met, or if the patient does not have insurance, arrangements must be made prior to seeing the medical doctor. **( ) Initials**

5. Medicare Patients: Cardiac Specialty Institute will file the patient's secondary insurance as a courtesy. Cardiac Specialty Institute will only bill one insurance company after Medicare. If we receive no response, the balance after Medicare pays will be the patient's responsibility. **( ) Initials**

6. If the patient has a HMO, obtaining authorization is the patient's responsibility for all visits, procedures, etc. If the patient chooses to be seen without an authorization, and the patient's insurance denies payment, the patient will be responsible for the entire bill. **( ) Initials**

Important Note: Please remember that the patien's coverage is a contract between the patient and the patient's insurance company. CARDIAC SPECIALTY INSTITUTE IS NOT PART OF THAT CONTRACT. Cardiac Specialty Institute files claims as a courtesy to the patient.

I, _____ (Print Name) has read and understand the above billing and insurance procedure.

_____ _____
Patient Signature Date

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Express and Informed Consent for Treatment

Patient Name _____ Date _____

I hereby authorize the professional staff of Cardiac Specialty Institute to administer a health assessment and treatment.

I understand that I am responsible for paying the fees at the time services are rendered.

I understand that more information will be provided for me before any tests will be performed, at which time my informed consent will be completed.

I understand that my consent can be revoked orally or in writing prior to, or during, the treament period.

I understand that my records are confidential but there are some exceptions . Cardiac Specialty Institute agrees not to release any of my information to anyone other than staff of Cardiac Specialty Institute and physicians involved in my care without my written consent (protected by State and Federal law). I understand there are times when the law requires that information be shared with authorities. These times would include cases with physical or sexual abuse, neglect of children, eldered, or disabled persons, and/or expression of intent to harm one's self or others. If Cardiac Specialty Institute has knowledge of a communicable disease that can harm others, the State requires we report data for follow up sdtudy if Cardiac Specialty Institute receives a court order requiring that we release information.

Patient Signature _____ Date _____