Cardiovascular Institute
of Palm Beach

New Patient Form

Service Acknowledgment

- Due to unexpected emergencies and procedures, there may be a wait. We apologize in advance for any inconvenience this may cause should this ever happen to you. Please understand that we are doing our best to see you in a timely manner and provide you with the finest care possible. Initials ______
- To help prevent the waiting times listed above, you may be seen by a Nurse Practitioner or Physician's Assistant. Shall you have any objections to this, or prefer to only see a physician, please notify our staff. Initials ______
- During your visit, the doctor may need to take urgent phone calls on either a cell or office phone. Please understand that such calls are unavoidable and are an integral part of patient care. Initials ______
- If it is required by your insurance, please understand that it is your responsibility to request and obtain a referral prior to any scheduled appointment. Initials ______
- You must come into the office for a follow up appointment to receive any testing or lab results. This information will not be given over the phone. Initials ______
- It is your responsibility to bring any records and/or test results with you for review. Initials ______

I acknowledge and understand all of the above statements.

Patient Name (please print): ____

Patient Signature: ____

Date: ____

1447 Medical Park Blvd., Suite 101, Wellington, Florida 33414 | 561 753 0001 | 561 753 0005
109A John F Kennedy Drive, Atlantis, Florida 33462 | 561 228 1995 | 561 469 7965

THE USE AND DISCLOSURE OF HEALTH INFORMATION

I, ____, understand that as part of my health care, EH CARDIOVASCULAR INSTITUTE OF PALM BEACH, originates and maintains paper and electronic records describing my health history, symptoms, examinations and test records describing my health care. I also understand that EH CARDIOVASCULAR INSTITUTE OF PALM BEACH uses a computerized medical record system and that infrequent typos may occur. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means through which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

  I understand and been provided with Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

  The right to review this notice prior to signing consent.
  The right to object to the use of my health information for directory purposes.
  The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment and healthcare operations.

I understand that EH CARDIOVASCULAR INSTITUTE OF PALM BEACH is not required to agree to the restrictions requested. I acknowledge that I may revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that EH CARDIOVASCULAR INSTITUTE OF PALM BEACH reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should EH CARDIOVASCULAR INSTITUTE OF PALM BEACH change their notice, they will send a copy of any revised notice to the address I have provided (U.S. Mail or, if agreed, by email).

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

☐ **I fully understand and accept the terms of this consent.**

Patient/Guardian Signature: ________________________________ Date: _______

For Office Use Only:
( ) Consent Received by: ______________________________________
( ) Consent Scanned on: ______________________________________
( ) Consent Refused by patient, and treatment as permitted.

PATIENT DEMOGRAPHICS

LAST NAME: ______________________________ **FIRST NAME:** ________________________ **MI:** ___

SSN: ______/______/______ **DOB:** ______/______/______ **AGE:** ________ **SEX:** M | F

ADDRESS: ____ **CITY:** ____________________________

STATE: ________ **ZIP CODE:** _________ **LANGUAGE:** ENGLISH | SPANISH | OTHER: ____________

HOME PHONE: ____________________________ **CELL PHONE:** ________________________________

EMAIL: __________________________________ **ADVANCED DIRECTIVE/LIVING WILL:** YES | NO

ETHNICITY: _______________________ **MARITAL STATUS:** SINGLE | MARRIED | WIDOWED | DIVORCED

PRIMARY CARE PHYSICIAN: ____________________________ **PHONE:** __________________________

EMERGENCY CONTACT: _______________________________ **PHONE:** __________________________

RELATIONSHIP TO PATIENT: SPOUSE | PARENT | CHILD | OTHER: ____________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________ **MEMBER ID:** __________________ **GROUP:** _______

PRIMARY INSURED: ___________________________________ **DOB:** ______/______/______

RELATIONSHIP TO PATIENT: SELF | SPOUSE | PARENT | CHILD | OTHER: _________________________

SECONDARY INSURANCE: _____________________ **MEMBER ID:** _________________ **GROUP:** ______

PRIMARY INSURED: ___________________________________ **DOB:** ______/______/______

RELATIONSHIP TO PATIENT: SELF | SPOUSE | PARENT | CHILD | OTHER: _________________________

PHYSICAL CONDITIONS HISTORY – PLEASE CHECK ALL THAT APPLY

☐ Hypertension	☐ Catheterization
☐ Diabetes	☐ Bypass Surgery
☐ High Cholesterol	Other Surgery:
☐ Coronary Artery Disease	Family History:
☐ Heart Attack	Allergies:
☐ Stroke	☐ Leg Claudication
☐ Heart Failure	☐ Arrhythmias
☐ Shortness of Breath	☐ Rheumatic Fever
☐ Angioplasty/Stent	

Smoking/Tobacco: Yes | No Frequency: __________ How long? __________

Alcohol Use: Yes | No Frequency: __________

☐ **I consent to be treated by EH CARDIOVASCULAR INSTITUTE OF PALM BEACH.**

AGREEMENT

I, the patient/representative, agree not to bring a frivolous malpractice case or cause of action against the physician or physician's legal entity providing care. Furthermore, should a meritorious medical malpractice case of cause of action be initiated or pursued, I, the patient/representative, agree to use an expert medical witness(es) who adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witness in the area(s) of medicine who would typically have the background and experience to opine on such a case. In consideration for this, I, the physician agree to the same stipulation.

Patient Signature: ______________________________ Date: _______________

INSURANCE ASSIGNMENT AND RELEASE AGREEMENT

I, _____________________________, the undersigned, have insurance coverage with ______________________ and assign directly to EH CARDIOVASCULAR INSTITUTE OF PALM BEACH/Dr _______________ all medical benefits if any otherwise payable for me for the services provided. I understand that I am financially responsible for all charges including the cost of Collection Agency Fees whether my insurance company pays or not. I hereby authorize EH CARDIOVASCULAR INSTITUTE OF PALM BEACH to release all necessary information to secure payment of benefits. I authorize the use of the signature on all my insurance submissions whether manual or electronic.

Patient Signature: ______________________________ **Date:** _______________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to either me or on my behalf to EH CARDIOVASCULAR INSTITUTE OF PALM BEACH/Dr ____________________ for any services provided to me by the Physician, Physician's Assistant and/or Nurse Practitioner. I authorize the release of any necessary information to the Health Care Administration to determine the benefits available for the service provided by my physician. I understand that by signing below, I am giving my physician/staff permission to request and collect payment. In addition, I am aware and authorize my physician to submit the medical and personal information necessary to collect payment. If other health insurance is indicated in item 9 of the HCFS 1500 form, elsewhere on other approved claim forms, or on information to my insurer/agency. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance (secondary insurance), and non-covered services. Co-insurance and the deductible are based upon the charge of determination of the Medicare Carrier.

Beneficiary Signature: ______________________________ **Date:** _________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted restrictions concerning the use and disclosure of my personal information:

____

____

Furthermore, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment. Regulation pertaining to medical assignment of benefits applies.

Patient Signature: _______________________________ **Date:** _______________________

☐ Patient refuses to sign the acknowledgement Date: _______________________

PATIENT PERMISSIONS TO THE PRACTICE

- We may leave test instructions, medication refill information, and/or appointment information on your voicemail or answering machine. **Circle one: YES | NO**
- We may give test instructions, medication refill information, and/or appointment information to an immediate family member. **Circle one: YES | NO**
- We may discuss your medical condition and/or diagnosis with an immediate family member. **Circle one: YES | NO**
- We may fax/send your medical records to your primary care physician, Dr ___________________. **Circle one: YES | NO**
- We may fax/send your medical records and insurance information to a hospital, doctor's office and/or relative. **Circle one: YES | NO**

Patient Signature: _______________________________ **Date:** _______________________

SYMPTOMS CHECKLIST

Patient Name: ______________________________ **Date:** ______________________

PLEASE CHECK ALL THAT APPLY:

GENERAL
( ) Weight loss or gain
( ) Fatigue
( ) Fever or chills
( ) Weakness
( ) Trouble Sleeping

SKIN
( ) Rashes
( ) Lumps
( ) Itching
( ) Dryness
( ) Color Changes
( ) Hair and Nail Changes

HEAD
( ) Headache
( ) Head Injury

EARS
( ) Decrease in hearing
( ) Ringing in the ears
( ) Earache
( ) Drainage

EYES
( ) Vision
( ) Glasses or Contacts
( ) Pain
( ) Redness
( ) Blurry or Double Vision
( ) Flashing Lights
( ) Specks
( ) Glaucoma
( ) Cataracts
( ) Date of Last Eye Exam __________

NOSE
( ) Lumps
( ) Discharge
( ) Itching
( ) Hay Fever
( ) Nosebleeds
( ) Sinus Pain

THROAT
( ) Teeth
( ) Dry Mouth
( ) Bleeding
( ) Dentures
( ) Sore Tongue
( ) Non-healing Sores
( ) Sore throat
( ) Gums
( ) Date of Last Dental Exam ________
( ) Hoarseness

NECK
( ) Lumps
( ) Swollen
( ) Pain
( ) Stiffness

BREASTS
( ) Lumps
( ) Pain
( ) Discharge
( ) Self Exams
( ) Breast Feeding

RESPIRATORY
( ) Cough (dry, wet or productive)
( ) Sputum (color and amount)
( ) Coughing Blood
( ) Shortness of Breath
( ) Wheezing

CARDIOVASCULAR
( ) Chest Pain
( ) Tightness
( ) Shortness of Breath w/activity
( ) Palpitations
( ) Difficulty Breathing Lying Down
( ) Swelling (edema)
( ) Sudden Awakening from Sleep with Shortness of Breath

PHARMACY INFORMATION

Patient Name: ______________________ **Date of Birth:** ____________________

Primary Pharmacy Name ____

Pharmacy Address (or cross streets) ____

City ________________________________ State __________ Zip Code __________

Pharmacy's Phone Number ____

Pharmacy's Fax Number ____

SECONDARY Pharmacy Name ____

Pharmacy Address (or cross streets) ____

City ________________________________ State __________ Zip Code __________

Pharmacy's Phone Number ____

Pharmacy's Fax Number ____

Cardiovascular Institute
of Palm Beach

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: ____

(PHYSICIANS NAME)

ADDRESS: ____

CITY: ____________________ STATE: ________ ZIP: ______________

PHONE: ____________________ FAX: ____________________

I, ______________________________________, would like to request my medical records released to

EH CARDIOVASCULAR INSTITUTE OF PALM BEACH

10131 FOREST HILL BLVD, SUITE 101

WELLINGTON, FL 33414

PHONE: 561.753.0001

FAX: 561.753.0005

PATIENT INFORMATION

PATIENT'S NAME: ____

DATE OF BIRTH: ____

PATIENT SIGNATURE: ____________________ DATE: ______________