**WELCOME**

We are honored that you have chosen us as your health care provider. We have exciting news regarding your health management with our practice.

As we continue our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with our patients to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the World Wide Web to track the most important aspects of your health care through our office. Our Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Patient Portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

\* Ask questions of doctors, nurses and staff members

\* Request refills and referrals

\* Schedule appointments

\* View your personal health records

\* Examine your current and past billing statements

…all from the comfort of your home, whenever it is convenient for you!

By using the Patient Portal, you no longer have to call the office, leave a message and wait for a return call to get the results of your test results; those results will be available to you through the Patient Portal. You can also send a message to the office through the portal and get a prompt reply.

To learn more or to sign up, contact our office today at 352-633-1966. Or, go to our website, [www.cvcfl.com](http://www.cvcfl.com), and follow the simple instructions to register.

Enroll today to take an active role in managing your health care!

**New Patient Survey**

Thank you for taking the time to answer a few questions about how you heard about our office. The information that you share will not be shared with others and will be used to better understand how to reach our patients.

How did you hear of our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen any of our ads in the following (please check all that apply):

Daily Sun

Daily Commercial

Healthy Living Magazine

Style Magazine

Word-of-mouth

Television

Doc-Talk’s or Hospitals

Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other/comments (please fill in): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for taking the time to fill out this brief survey. If you would like for someone to contact you regarding our services please let an administrative assistant at our front desk know.

*(For office use only)*

PN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of survey: \_\_\_\_\_\_\_\_\_\_\_

**Patient Registration Form**

**Please Print Clearly and answer all questions Today’s Date:**

**Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MI:** \_\_\_\_

**Age** \_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_\_\_\_ **Marital Status**: S/ M/ D/W/Other

**Soc. Sec. #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Language Preference:** English /Spanish /Other: \_\_\_\_\_\_\_\_

**Race:** Black / White / Asian / Hispanic /Unreported **Ethnicity:** Hispanic / Not Hispanic/ Unreported

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Local Mailing Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have out of town address, please list below:**

**Address** \_\_\_\_\_\_\_\_\_\_

**Phone Number** ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Seasonal Y/N Leave \_\_\_\_\_\_\_\_ Back\_\_\_\_\_\_\_\_\_**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(To get access to your medical records/Communicate with practice)**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Emp.Status**: Full time/ Part time/ Retired/ Unempl.  **Military**: Active / None Active\_\_\_

**If Applicable: Employer** **Occupation**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***List Your Emergency Contact**

**Name** \_\_\_\_\_**Relationship**\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Office Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete all Prescriptions are forwarded electronically to your pharmacy.**

**Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

RESPONSIBLE PARTY OR PRIMARY INSURANCE SUBSCRIBER

Relationship to patient: Self/ Spouse/ Child/ Other:

**If Not Self:**

Soc. Sec. #: Date of Birth / / Gender M/F

Last Name First Name MI

Address

City State Zip

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

(***PLEASE PRESENT ALL INSURANCE I.D. CARDS AND PHOTO ID TO THE RECEPTIONIST)***

**Primary Insurance Company Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_Copay Amount $ \_\_\_\_

**Secondary Insurance Company Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name \_\_\_\_\_\_ \_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Copay Amount $

**Please answer the following Questions Below**

Do you have an Advance Directive? YES / NO

Do you give consent for CVC have permission to view your prescription history from external sources? YES / NO

Can we share your prescription information with other medical providers? YES / NO

Can we release medical record information to the insurance company to process the claim? YES / NO

Can we release medical records information to providers listed in your chart? YES / NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative Date Witness Signature Date**

**Authorization for Treatment / Release of Information**

**Consent to Treatment**: The patient and/ or authorized representative do hereby consent to any and all treatments which may deem advisable by the physician or Cardiac and Vascular Consultants, Inc. Patient Consent to Rx verification. Each procedure and diagnostic study will be discussed in detail with patient before procedure is performed. Additional consent will be required at the time of procedure.

**Assignment of Insurance Benefits**: I assign payment directly to Cardiac and Vascular Consultants, Inc. Insurance Benefits otherwise payable to me. I understand that I am financially responsible for charges paid by this assignment. I will assist in the collection of my insurance should there be any delay in payment. I agree to actively participate in collecting Insurance payment for any claims unpaid after 30 days. If after 45 days the claim remains unpaid, I understand the balance will be due from me.

**Medicare Patients**: I certify that the information given by me in applying for payment under the XVIII if the Social Security is correct. I authorize Cardiac and Vascular Consultants, Inc. to release to the Health Care Financing Administration of its Intermediaries any information needed for this related Medicare claim, I hereby authorize payment directly to Cardiac and Vascular Consultants, Inc for medical benefits otherwise payable to me as beneficiary of the Medicare Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but limited to routine testing may not be covered by Medicare unless the Physician provides medical necessity.

**Patient/ Guarantor Agreement**: I understand that Cardiac and Vascular Consultants, Inc. is not in business expanding credit. Therefore, it is the policy of Cardiac and Vascular Consultants, Inc. to require payment in full at the time of service. If unable to pay due balance in full at the time of service, I agree to make prior arrangements with the Billing Department.

I understand that I am financially responsible for my/ the patient’s account with Cardiac and Vascular Consultants, Inc. regardless of my insurance benefits. I authorize copies of this form to be valid as the original.

**Patient/ Responsible Party:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative Date Witness Signature Date**

**Patient Consent for Use and Disclosure of**

**Protected Health Information**

I hereby give my consent for Cardiac and Vascular Consultants to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cardiac and Vascular Consultants reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cardiac and Vascular Consultants.

With this consent, Cardiac and Vascular Consultants may call my home or other alternative location, and leave a detail message on voice mail or e-mail/text me in reference to any items that assist the practice in carrying out TPO. This may include appointment reminders, insurance issues, and concerns with my clinical care, such as laboratory test results, diagnostic imaging, etc.

With this consent, Cardiac and Vascular Consultants may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “ Personal and Confidential.”

With this consent, Cardiac and Vascular Consultants may text or e-mail to my home or alternative location, any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, and medical records. I have the right to request that Cardiac and Vascular Consultants restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Cardiac and Vascular Consultants to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, or later revoke it, Cardiac and Vascular Consultants may decline to provide treatment to me.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative Date Witness Signature Date**

**Notice of Privacy and Authorization Form**

I acknowledge that I have received a copy of Cardiac and Vascular Consultants Privacy Practice.

(located in Main Lobby).

In the event that a copy of my personal information is needed for reasons other than immediate treatment, I hereby authorize the release of information to the following family member or friend, acting on my behalf.

Name: \_\_\_\_ Phone:\_\_\_\_ \_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Phone: \_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_ Phone:\_\_\_\_ \_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Phone: \_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

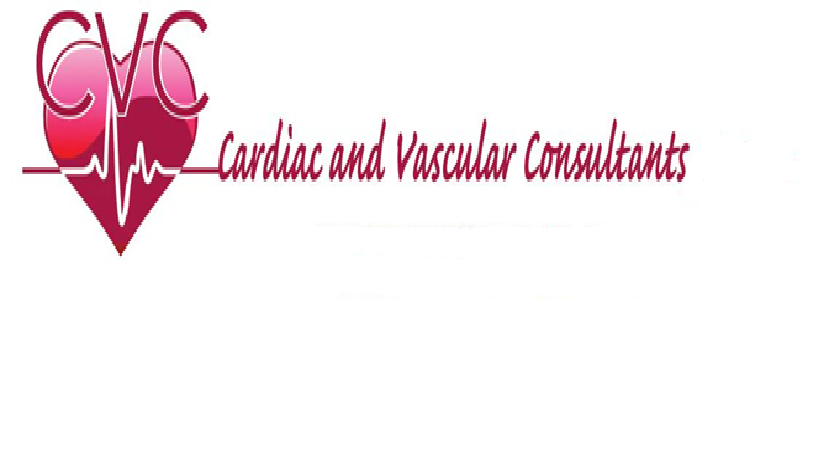
Name: \_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please choose one of the options below:**

□ **I understand that I may amend this authorization at any time, until then this form will be kept on file until further changes are made. I also understand that any other request for personal health information by anyone other than those listed will require additional authorization by me in writing**.

□**I refuse to have any information be released to anyone, this includes: Family members, Providers, or friends, acting on my behalf.**

Patient: (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative Date Witness Signature Date**

**Authorization For Release Of Medical Information**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_ authorize **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (“Provider”) of Cardiac and Vascular Consultants, to disclose protected health information (“PHI”) regarding:

Patient Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_, Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the PHI be disclosed at my individual request to **Cardiac and Vascular Consultants** at the following location:

\_\_\_ Creekside Medical Plaza 1050 Old Camp Road Ste. 270 The Villages, FL 32162 Ph: 352-633-1966\* Fax: 352-633-1969

\_\_\_ Conard Plaza 4224 West Gulf To Lake Highway, Lecanto, FL 34461\* Ph: 352-513-3482\*Fax: 352-513-3489

**Check One:** I authorize the following PHI to be released:

\_\_All health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information good for **one year** of the date signed.

\_\_For a **limited time period beginning\_\_\_\_\_\_\_\_\_\_\_\_ and ending\_\_\_\_\_\_\_\_\_\_\_\_** all health information about the patient in the possession of Provider, including, but not limited to psychiatric ,mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information.

\_\_Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed **(ii):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_Other, as described here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Release to:**

|  |  |
| --- | --- |
| **Name of Organization/Person** |  |
| **Address of Organization:** |  |
| **Phone Number :** | **Fax Number:** |

1. Psychotherapy notes are notes by a mental health professional documenting private counseling stored separately from the chart. To release them requires a separate release.
2. The Provider is authorized by law to use or disclose PHI for a variety of reasons without the patient’s authorization. Please see the Provider’s Notice of Privacy Practice for details. This Authorization was developed to comply with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, the health Information Technology for Economic and Clinical Health (HITECH) Act, the American Recovery and Reinvestment Act (ARRA) of 2009 and associated regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative Date Witness Signature Date**

**ADVANCED DIRECTIVES**

(For Compliance with the Patient Self-Determination Act)

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| Have you executed an advanced directive? YES \_\_\_\_\_\_ NO \_\_\_\_\_\_  If YES, is this directive in the form of:  \_\_\_\_ A Living Will  \_\_\_\_ A Durable Power of Attorney  \_\_\_\_ A Health Care Surrogate (Someone to make decision for you)  \_\_\_\_\_\_ DNR ( Do Not Resuscitate)  Have you provided this office with a copy of Advanced Directive?  YES \_\_\_\_\_ NO \_\_\_\_\_  If you would like more information regarding advanced directives please ask the nurse or receptionist. Forms are supplied in the office lobby for you |

|  |
| --- |
| I have been provided with information regarding the “PATIENT SELF-DETERMINATION ACT” |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or representative Date

Have you executed an advanced directive? YES \_\_\_\_\_\_ NO \_\_\_\_\_\_

If YES, is this directive in the form of:

\_\_\_\_ A Living Will

\_\_\_\_ A Durable Power of Attorney

\_\_\_\_ A Health Care Surrogate

Have you provided this office with a copy of Advanced Directive?

YES \_\_\_\_\_ NO \_\_\_\_\_

If you would like more information regarding advanced directives please ask the nurse or receptionist.