



Cardiac and Vascular Consultants

*Shrikanth Upadya, M.D., FACC * Vishnu Yelamanchi, M.D., FACC * Basel Al Aloul, M.D., BCh, FACC*

*Usman Hashmi, M.D. * Toralben K. Patel, M.D., MPH, FACC * Rama K. Krishna M.D., FACC*

*James Bryant Pate, ARNP * Gretchen McCabe, ARNP*

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, and follow the simple instructions to register.

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

Creekside Medical Plaza, 1050 Old Camp Rd., Ste. 270, The Villages, FL 32162 * LPMC Medical Plaza, 709 Physician's Ct., Leesburg, FL 34748

Sabal Palms Plaza, 510 Hwy 466, Ste. 105/106, Lady Lake, FL 32158 * Ph: 352-633-1966, Fax: 352-633-1969,

New Locations: 4224 west Gulf To Lake Highway, Lecanto, FL*34461*Ph:352-513-3482*Fax:352-513-3489

1858 Mayo Drive, Tavares, FL 32778, Ph: 352-633-1966, Fax: 352-633-1969

Web: www.cvcfl.com



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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: _____



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Patient Registration Form

Please Print Clearly and answer all questions

Today's Date _____

Last Name: _____ First Name: _____ MI: _____

Primary Address _____

Secondary Address: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Age _____ Date of Birth _____ Gender: Female /Male / Transgender F or M

Marital Status: S/ M/ D/ W/ Other Soc. Sec. #: _____

Email: _____ **(To get access to your medical records from practice)**

Employee Status: Full time/ Part time/ Retired/ Unempl. **Military:** Active / None Active

If Applicable: Employer _____ Occupation _____

Emergency Contact Name: _____ Relationship _____ Phone () _____

Referred by: Name _____ Number: _____

Primary Care Physician: _____ Office Location: _____

Address: _____ Phone: _____

Pharmacy: _____ Location: _____ Phone: _____ Fax: _____

Pharmacy: _____ Location: _____ Phone: _____ Fax: _____

All Prescriptions are forwarded electronically to your pharmacy and Verified also with E force.

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**

Can we Electronically Send and Receive Medical Records through Integrated Data Exchange? **Yes /No**

Patient Signature: _____ Date: _____



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Please answer all the questions: The below questions are required to be asked by State Law for Census

Language Preference: English / Spanish / Russia/Indian (includes Hidi)/Other: _____

Race: Black / White / Asian / Hispanic /American Indian or Alaska Native/Other/Refuse to report

Ethnicity: Hispanic / Not Hispanic/ Refuse to report

Residence Type: Private Home/ Residential Home/Skilled Nursing Home/ Nursing Home/ Homeless

Your Birth Child Order: 1 2 3 4 5 6 7 8 9 10

VFC Eligibility: YES/NO, if yes what eligibility do you have: _____

Are You a Veteran: Yes / No if so are you: Active or Inactive

Are you Seasonal: Yes / No if so when do you leave _____ and Return _____

Are you a Migrant: YES / No Are you Homeless: Yes/No Public Housing: Yes/ No

Limited English Proficiency: Yes/No

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 TO THE RECEPTIONIST)

Primary Insurance Company Name: _____

Insurance Address: _____ Phone: _____

Insured Name _____ Employer _____

Policy Number: _____ Group Number: _____ Copay \$ _____

Secondary Insurance Company Name:

Address: _____ Phone: _____

Insured Name _____ Employer _____

Policy Number: _____ Group Number _____ Copay \$ _____

Patient or Legal Representative Signature Date Witness Signature Date

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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, Electronic Data Health Exchange (eEHX Interoperability). 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: _____

_____	_____	_____	_____
Patient or Legal Representative Signature	Date	Witness Signature	Date



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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 message on voice mail or e-mail/text me, publish my records to patient portal 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, Integrated Data records Exchange (eEHX), Marketing, 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 Name Printed: _____

_____	_____	_____	_____
Patient or Legal Representative Signature	Date	Witness Signature	Date



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Authorization For Release Of Medical Information

Date: _____

I _____ authorize Vishnu Yelamanchi ("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 by Paper, Electronically Shared, Integrated Data Exchange:

___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 PHI (To) or (Obtain PHI) from: see below

Table with 2 columns: Name of Organization/Person, Address of Organization, Phone Number, Fax Number

(i) Psychotherapy notes are notes by a mental health professional documenting private counseling stored separately from the chart. To release them requires a separate release.

(ii) 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.

Patient or Legal Representative Signature Date Witness Signature Date



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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, Providers, 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: _____

_____	_____	_____	_____
Patient or Legal Representative Signature	Date	Witness Signature	Date



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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. **All forms are provided in the lobby**

I have been provided with information regarding the "PATIENT SELF-DETERMINATION ACT"

Signature of patient or representative

Date



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Communications Refusal

I, _____, recommend being contacted by Cardiac and Vascular Consultant, by the following communication indicated below.

- | | | |
|--------------------------|------------|------------|
| Telephone Communication | ___ Accept | ___ Reject |
| Written Communication | ___ Accept | ___ Reject |
| Text Messaging | ___ Accept | ___ Reject |
| Email | ___ Accept | ___ Reject |
| Patient Portal | ___ Accept | ___ Reject |
| Appointment Confirmation | ___ Accept | ___ Reject |
| Test Result | ___ Accept | ___ Reject |

_____ I refuse **ALL** of the above communications. I understand that this means that the office will not be able to communicate with me in any way and I understand the risks involved. Should an emergent test result or situation arise, the office/ physician will not be able to contact me in any way.

Please be aware that due to HIPAA compliance this form will be adhered to and not deviated from. You may change your designations above by filling out a new form and submitting it to the office. The form is in effect for one year, unless written notification is given otherwise.

Patient Signature _____ Date: _____

Witness Signature _____ Date: _____