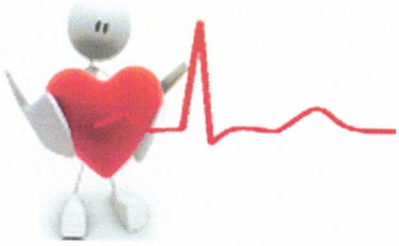
David Henderson, MD
Nathan Valin, MD
Dinesh Arab, MD
Barton Sickinger, D.O
Rene Celis, MD
David Bamberger, PA
Melissa Clegg, NP
Mary Wittnebert, NP
Sharon Hesher, NP

305 Memorial Medical Parkway
Suite 301
Daytona Beach FL 32117-5168

Phone: 386-677-5351
Fax: 386-673-2787

www.cardiologyphysicians.org

New Patient Packet



Cardiology Physicians, Memorial, LLC

Please be Sure to Bring The Following To Your First Appointment

- **A PHOTO ID**
- **ANY/ALL INSURANCE CARDS**
- **CO-PAYMENT**
- **MAKE A LIST OF ALL CURRENT MEDICATIONS & DOSAGE.**

We prefer the actual bottles: this allows us to see the strengths and dosage.

Please allow at least two hours for a new patient appointments.

Please do not wear lotions on the day of your appointment. Also, please "no" dresses. Two-piece clothing is preferred. (The attire will allow us to perform the EKG)

It is very important that you complete your packet before your arrival.

We look forward to meeting you. Please call our office if you have any questions (386) 615-1521

Advent Hospital Medical Office Building
305 Memorial Medical Parkway
Suite 301 – Third Floor
Daytona Beach, FL 32117

CARDIOLOGY PHYSICIANS

Welcome to our practice. We are pleased you have decided to let us attend to your Cardiac Health. You have an appointment with Dr._____on _____. The amount you will be required to pay at the time of service is $_____. This could be due to your copay, coinsurance and/or deductible.

Records: Your primary care physician has either agreed to send us records or given records to you. If you have the records please either mail them or drop them by so we can make sure they include the test our doctors require. Please complete the forms in this packet before your visit and bring them with you.

Previous Cardiac History: If you have already seen a Cardiologist (either here or elsewhere) it is important that we have those records also. Please obtain them and send us a copy. We need reports of any echocardiograms, heart caths, PTCA's, stents, or bypass surgery you may have had.

Medicines: PLEASE BRING THE BOTTLES OF ALL MEDICINES YOU ARE CURRENTLY TAKING. Include vitamins, aspirin, and other over-the-counter medicines. Also list medicine on paperwork to follow.

Office Hours: We are open from 8:30 a.m. - 5:00 p.m. We see patients by appointment only.

Emergencies: One of our Cardiologists is always on call and available for emergencies or symptoms that require attention. Please do not call "after hours" or during lunch with routine questions or prescription requests.

Prescriptions: When possible, have your pharmacy fax (not call) a request for refills. We will process the request within 48 hours unless it is faxed on the weekend. Do not call and expect the prescription available the same day. In most cases, we are too busy caring for patients and attending to emergencies to handle refills that quickly.

Communication: We try to get back to patients who call as soon as possible. We do, however, see patients in the hospital and office and to avoid running chronically behind with our appointments most non-emergent calls are not returned until late in the day. We will call test results as soon as we have the report and it has been reviewed. This may take some time. If you have an office visit scheduled within a week or so of the test the doctor will discuss the results with you in person at that time.

Cancellations/No Show Appointment: You will be charged a fee of $25 for a missed appointment if not canceled at least 24 hours in advance.

Cardiology Physicians

Patient's Personal Information

Confidential Record: Information contained here will not be released unless you have authorized us to do so.

Date: _____

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ Age: _____ Country of Birth: _____

Referring Doctor/Person (include address if not local) _____

Briefly Describe the Reason for Today's Visit:

_____

_____

_____

_____

_____

Past Medical History:

Have you had any of the following?

	Yes	No	Year Began
Angina			
Heart Attack			
Other Heart Disease			
Rheumatic Fever			
High Blood Pressure			
Diabetes			
Lung Disease			
Cancer			
Nervous Breakdown			
Other			

Operations or Hospitalizations:

Description	Year

Family History:

	Age:	Alive?	Heart Disease?
Father			
Mother			
Brother			
Sister			
Sons			
Daughters			

Medications you are currently taking:

Name of Medicine	Dose	Times Per Day

Cardiology Physicians

Patient's Personal Information

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Medication Allergies (Describe Reaction)

_____

_____

_____

_____

Personal Habits:

Do you smoke? _____

If yes, # of years? _____

Amount: _____

Frequency: _____

Cigarettes / Pipe / Cigars (Circle ones that apply)

Do you drink alcohol? _____

If yes, # of years? _____

Frequency: _____

Beer / Wine / Liquor (Circle ones that apply)

Have you ever used recreational drugs? _____

OTHER PROBLEMS: (Circle ones that apply) Chest pain, shortness of breath, leg swelling, cough, heartburn, dizziness, nausea, vomiting, diarrhea, burning or painful urination, weakness in arms or legs, loss of vision, headaches, other _____.

Cardiology Physicians

Patient's Registration Form

Patient Information

Name/First M.I. Last SS#

Street Address or PO Box City State Zip

Home Phone Work Phone Cell Phone

Birthdate Age Gender Race Marital Status Spouse's Name

Patient Employer Patient's Occupation

Address City State Zip

Primary Care Doctor: _____

Pharmacy Name: _____

Pharmacy Address: (need at least street name) _____

City: _____ Phone Number: _____

Do you use a mail away Pharmacy? If yes, what is the name: _____

Preferred Lab Company: _____

Surrogate Decision-Maker/ Medical Power of Attorney: _____

Would you like to be web-enabled so you can view your medical records online?

Yes _____ No _____ Email address: _____

Cardiology Physicians

Patient's Registration Form

Insurance Information

Primary Insurance Company **Phone Number**

Street Address or PO Box **City** **State** **Zip**

Insured's Name **ID #** **Group #** **Birthdate**

Secondary Insurance Company

Street Address or PO Box **City** **State** **Zip**

Insured's Name **ID #** **Group #** **Birthdate**

Do you want us to discuss your medical condition, including test results with anyone other than yourself? If yes, list up to three people / Emergency Contacts below:

Name **Relationship** **Phone Number**

1. _____
2. _____
3. _____

Insurance Authorization and Assignment

I hereby authorize Cardiology Physicians P.A., to furnish information to Insurance Carriers concerning my illness and treatment and I hereby assign to the Physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by Insurance.

Signature: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient: _____

Witness (if signed by someone other than patient) _____

Cardiology Physicians

Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Cardiology Physicians originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. 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 by 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 have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosure. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purpose, and

the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Cardiology Physicians is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent 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 Cardiology Physicians reserves the right to change their notice and practice and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Cardiology Physicians change their notice, will send a copy of any revised notice to the address I've provided.

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

I fully understand and accept the terms of this consent.

Patient's Signature: _____

Date: _____

Cardiology Physicians

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Cardiology Physicians Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____

_____

Acknowledgement of our Policies

I acknowledge that if my account becomes delinquent and gets turned over to a collection service, there will be a $20.00 collection fee added to my balance due.

I give Cardiology Physicians the authority to communicate with me via any phone number that I provide to them.

Signed:_____ Date:_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

RELATIONSHIP:_____ WITNESSED BY:_____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please Document the date the time the notice was presented to patient and sign below.

Presented on (date and time):_____

By: (name and title):_____

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Authorization for Use or Disclosure of Protected Health Information
REQUEST FOR RELEASE OF INFORMATION

Name and address of the physician or hospital from which data is requested: _____

_____

_____

Name and address of physician or hospital where data can be sent to: _____

_____

_____

Patient Name:

Date of Birth:

SS#

Address:

I authorize my physician and/or practice's administrative and clinical staff to use and/or disclose health information about me as described below.

1. Description of the information to be used or disclosed (check all that apply):
   ___ Medical information relating to a specific medical condition (describe condition):
   ___ Laboratory, radiological or other test results (describe condition) _____
   ___ The patients entire medical records related to Cardiology Physicians
   ___ Other_____

2. This protected health information relating to a specific medical condition (describe condition):
   ___ At the request of the patient.

3. I understand that I have the right to revoke this authorization. in writing at any time by sending written notification to the practice's Privacy Officer at Cardiology Physicians Memorial. I understand that a revocation is not effective to the extent that my physician has relied on this authorization prior to receiving notice of revocation or my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that if the person or entity that receives the health information described above is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulation, the information described above may be re-disclosed by the recipient and will no longer be protected by the privacy regulation.

5. I hereby authorize the release of my medical records to the requested physician. This information is to include alcohol, drugs, sickle cell anemia, and HIV. I understand that this may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire after the requested information has been supplied.

   Signature of Patient or Personal Representative: _____ Date:_____

Cardiology Physicians

INSURANCE AND BILLING POLICIES

Due to the vast number of insurance companies and the complex rules and constant changes, we have prepared the following information to help you understand our polices.

If you have an insurance that requires an authorization for your office visit or any procedures, please make sure to contact your primary care physician prior to the visit so that we will not have to reschedule the appointment.

You are responsible for any co-payments or deductibles at the time of service. If your insurance company does not respond to the claim within 60 days the amount will be transferred to you for payment. It is your responsibility to contact your insurance company for payment (we will assist you if you have questions, however sometimes they will only pay once the patient has contacted them).

A $50 fee will be charged for any paperwork such as disability, etc. that must be prepared by our clinical staff.

Any Medical Records copied per your request will be charged at: $1.00 per page for the first 25 pages and then $.25 for each page thereafter.
We accept cash, local checks, VISA, MasterCard, and Discover Card. If you are unable to pay your balance in full, a payment schedule can be arranged with our insurance specialist.

We appreciate the opportunity to serve you and hope this information is helpful. If you have any questions please do not hesitate to ask us.