

PATIENT REGISTRATION FORM (eCW)

Florida Heart & Vascular - Aventura

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last) _____ (First) _____ (MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline): _____ Cell: _____ Work: _____

E-Mail Address: _____ Date of Birth: _____

Gender Identity: Female Male Transgender Female to Male Transgender Male to Female Genderqueer Choose not to disclose
 Additional Gender category not listed _____

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White
 Hispanic Chose not to disclose Other not listed _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Choose not to disclose

Preferred Language: English Spanish ASL Japanese Mandarin Korean French Indian: Hindi, Tamil, Gujarati etc
 Swahili Russian Arabic Vietnamese Haitian Creole Bosnian/Croatian/Serbian/Serbo-Croatian
 Albanian Burmese Tagalog Farsi-Iranian/Persian Portuguese Cambodian Other not listed _____

Patient Social Security Number: - - - - -

RESPONSIBLE PARTY INFORMATION (If not self)

(Information used for patient balance statements)

Responsible party: Another patient Guarantor Self Check here if address and telephone information is same as patient

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM ____ /DD ____ /YYYY ____ Sex: Female Male

Responsible Party Social Security Number: - - - - - Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? Yes No

Emergency contact relationship to patient: _____ Guardian

Address: _____

City, State: _____ ZIP: _____

Home phone: _____ Work hone: _____ Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

FLORIDA HEART AND VASCULAR CARE

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT FINANCIAL AGREEMENT

1. _____ (Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, **FLORIDA HEART AND VASCULAR CARE** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____ (Patient or Guardian Initials)

Third Party Collection. I acknowledge that **FLORIDA HEART AND VASCULAR CARE** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ (Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to **FLORIDA HEART AND VASCULAR CARE** any insurance or other third-party benefits available for health care services provided to me. I understand **FLORIDA HEART AND VASCULAR CARE** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **FLORIDA HEART AND VASCULAR CARE**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ (Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **FLORIDA HEART AND VASCULAR CARE** by the Medicare or Medicaid program.

5. _____ (Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for **FLORIDA HEART AND VASCULAR CARE**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **FLORIDA HEART AND VASCULAR CARE** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **FLORIDA HEART AND VASCULAR CARE** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ (Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X _____ Date _____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

- | | |
|----------------|------------------------------|
| Spouse | Guarantor |
| Parent | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify) _____ |

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name

Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)
-----------------------------	------------------------------	----	----------------------------

Notice of Privacy Practice/clinics

_____ (Patient/Representative initials) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

FL Heart & Vascular Care at Aventura - 21097 NE 27th CT, Suite 480 - Miami, FL 33180

Ph: (786) 428-1059 - Fx: (786)428-1062

Medication List

Name: _____

Pharmacy: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Allergies: _____

#	Start Date	Stop Date	Prescribes By	Medication Name/Dosage/Route/Frequency
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

Name: _____

REVIEW OF MEDICAL SYSTEMS

Are you currently having any problems related to the following systems? Circle Yes or No

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Weight Loss/Gain	Yes	No

Allergic/Immunologic

Food Allergies	Yes	No
Drug Allergies	Yes	No

Endocrine

Excessive Thirst	Yes	No
Too Hot/Cold	Yes	No
Tired/Sluggish	Yes	No

Cardiovascular

Chest Pain	Yes	No
Blood Clotting Problem	Yes	No
Swelling Legs	Yes	No
High/Low Blood Pressure	Yes	No

Respiratory

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No

Breast

Breast Pain	Yes	No
Nipple Discharge	Yes	No
Breast Lumps	Yes	No
Abnormal Mammogram	Yes	No

Neurological

Headaches	Yes	No
Dizzy Spells	Yes	No
Numbness/Tingling	Yes	No

Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No

Gastrointestinal

Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No
Indigestion/Heartburn	Yes	No

Integumentary (skin)

Skin rash	Yes	No
Boils	Yes	No
Persistent Itch	Yes	No

Psychologic

General Satisfaction with your life	Yes	No
Severe Depression	Yes	No
Considering Suicide	Yes	No

Genitourinary

Urine Retention	Yes	No
Painful Urination	Yes	No
Urinary Frequency	Yes	No
Unusual Vaginal Discharge	Yes	No
Unusual Vaginal Bleeding	Yes	No
Unusual Itching/Odor	Yes	No
Trouble Getting Pregnant	Yes	No

New Patient Information Form

Patient _____ Date of Birth _____ Date _____

Family Doctor _____

Check Yes or No

Medical Problems: Have you had (or do you have now) any of the following medical problems:

- | | | | |
|--|--|--|---|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Other Cancer | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Other Kidney Disease |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Abnormal PAP | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Received Blood Transfusion |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> <input type="checkbox"/> Liver/pancreas disease | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> <input type="checkbox"/> Positive HIV or AIDS | Other (Please describe) _____ | | |

Past Surgery: Have you had any of the following operations and the year

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Appendix _____ year | <input type="checkbox"/> Gall Bladder _____ year | <input type="checkbox"/> Thyroid _____ year | <input type="checkbox"/> Hysterectomy _____ year |
| <input type="checkbox"/> Hernia _____ year | <input type="checkbox"/> Heart _____ year | <input type="checkbox"/> Lung _____ year | <input type="checkbox"/> Spine/joint _____ year |
| <input type="checkbox"/> Tonsils _____ year | Other (Please describe) _____ | | |

PATIENT SOCIAL HISTORY

- Marital Status: Single Married Separated Divorced Widowed
- Use of Alcohol: Never Rarely Moderate Daily Previously, but quit
- Use of Tobacco: Never Previously, but quit Current _____ Packs a Day
- Use of Drugs: Type _____ Frequency _____

FAMILY MEDICAL HISTORY

	AGE	DISEASE	DECEASED/CAUSE OF DEATH
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling (1)	_____	_____	_____
Sibling (2)	_____	_____	_____
Sibling (3)	_____	_____	_____
Sibling (4)	_____	_____	_____



Signature _____

Date _____

Electronic communications will be viewed by not only the physician, but the staff members assigned to handle such communications and any other provider covering for the patient's physician if the patient's physician is unavailable to respond. Applicable law may allow a health care professional to determine that a minor patient is "mature" to keep a portion of the minor's medical information confidential. If the minor patient is determined "mature" by his or her physician, all Patient Portal communication will be with the minor directly and a new consent form with the minor's email address will be required.

Applicable law may also permit confidential communication with a minor patient in regards to treatment and reporting of sexually transmitted diseases to the minor and communications with pregnant minors in regards to questions about the health of her fetus. In these situations, all Patient Portal communications will be directly with the minor and a new consent form with the minor's email address will be required.

The Practice will keep a copy of all medically important online communications in your medical record secure pursuant to applicable federal and state laws and regulations. Print or store in a secure place (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you.

The Practice will not forward online communications with you to third parties except as authorized or required by law.

Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools as noted above.

Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an online communication did not receive a response.

You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. The Practice is not responsible for breaches of confidentiality caused by you or an independent third-party.

Guidelines for Safe Online Communications

Take steps to keep your online communications to and from the Practice confidential, including:

Do not store messages on your employer-provided devices (e.g. computer, cell phone, tablet, etc.); otherwise personal information could be accessible or owned by your employer.

Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private.

Do not allow other individuals or third parties access to the devices(s) upon which you store medical communications.

Keep your login and password information secure and confidential.

Do not use email for medical communications. Standard email lacks the necessary security and privacy features and may expose medical communications to employers or other unintended third-parties.

Access to Online Communications

The following pertains to access to and use of online communications:

Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement.

The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information

Print Patient Name: _____ Date of Birth _____

Email address: _____



Signature _____

Relationship _____

Date _____

- I am over the age of 18 and have sole responsibility of my medical care
 - Yes
 - No (We do not offer the Patient Portal to minors or those patients which do not make their own medical decisions at this time. We apologize for the inconvenience).

- I choose not to participate in Patient Portal at this time because:
 - I do not have an E-mail address
 - I do not wish to share my E-mail address
 - English is not my preferred language
 - Other

Please DO NOT use Patient Portal to communicate with your Practice for urgent or emergency medical issues. If you are experiencing an urgent medical need, please contact us by phone.

For emergencies call 911.

Patient Portal User Agreement and Consent

Effective: August 10, 2012

The Patient Portal (defined below) is owned and operated by the practice to which you are seeking to online access (the "Practice"). The Practice has adopted this user agreement ("User Agreement" or "Agreement") to make you aware of the terms and conditions of your use of the Patient Portal and any derivative websites of the Patient Portal (collectively, the "Patient Portal"). In the event that you purport to be the agent of, represent, or otherwise act on behalf of any other person, references to "you," "your" or "User" shall include such entity or person in addition to such representative, and your acceptance of this Agreement shall constitute acceptance on behalf of such person.

The Practice uses reasonable efforts to maintain the Patient Portal, but the Practice is not responsible for any defects or failures associated with the Patient Portal, any part thereof or any damages (such as lost profits or other consequential damages) that may result from any such defects or failures. The Patient Portal may be inaccessible or inoperable for any reason, including, without limitation: (a) equipment malfunctions, (b) periodic maintenance procedures or repairs which the Practice may undertake from time to time or (c) causes beyond the control of the Practice or which are not foreseeable by the Practice. In addition, the Practice makes no guarantees as to the web sites and information located worldwide throughout the Internet that you may access as a result of your use of the Patient Portal, including as to the accuracy, content, or quality of any such sites and information or the privacy practices of any such site. The Practice is not a backup service for storing data you submit to the Patient Portal, and the Practice shall have no liability regarding any loss of such data. You are solely responsible for creating backups of any data you submit using the Patient Portal.

The Patient Portal is a secure website that allows you to use a computer to interact with medical information via the internet. The Patient Portal also allows you to communicate with the Practice via secure messaging. Please note that all communication via the Patient Portal will be included in your permanent patient record.

Responsibilities, Risks and Benefits:

The Patient Portal is provided as a convenience to you at no cost and is only available in English at this time. We do not sell or give away any private information, including email addresses. We reserve the right to suspend or terminate the Patient Portal access at any time and for any reason.

All messages sent to you will be electronically secure. Messages and emails from you to any staff member must be sent through the Patient Portal for security and confidentiality reasons.

The Patient Portal messages will be handled by our staff in a manner similar to how phone communication is handled.

Although we strive to reply to Patient Portal messages within one business day, we cannot guarantee that we will be able to address your messages in that timeframe. We encourage you to use the Patient Portal at any time but understand that we can only reply to messages during our office hours, excluding holidays recognized by the Practice. If you do not receive a response within two business days, please feel free to call our office.

You are responsible to provide us with your correct email address and inform us immediately of any change. You are also responsible for the protection of your login information and password.

Please understand that all electronic communications carry some degree of risk, even in a secured environment. Even with all due precautions, online communications may be intercepted, forwarded or changed without a patient's or the healthcare provider's knowledge. By using or accessing the Patient Portal, you expressly accept these risks. Note that it is easier for a patient's identity to be stolen or for someone to try to impersonate a patient via online communication.

Online communications are admissible as evidence in court just as medical records are in the event the physician-patient privilege is waived or if a court orders disclosure.

Online communications may disrupt or damage a computer if a computer virus is transmitted via an attached file, hyperlink or other method. You assume liability for such disruptions or damages caused by such transmissions.

Responses to online communications are limited by the information provided and your question may necessitate a follow-up phone call or a request to meet with you in person to gain further information.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section ONLY if NA to your practice/clinic

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- **I do want** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- **I do not want** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

