FLORIDA HEART & VASCULAR CARE Of Broward

PATIENT REGISTRATION FORM

PATIENT INFORMATION

(Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr.

Patient's Name (Last)_____ (First)_____ (Middle)_____

Date of Birth____/____/____ ☐ Female ☐ Male Social Security Number____-____-____

Race ☐ White ☐ Black / African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Other ☐ Refused to Report

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Phone Numbers Home_____ ☐ Day ☐ Evening Work_____ ☐ Day ☐ Evening

Cellular_____ Language English ☐ Spanish ☐ French/Creole ☐ Other ☐

Address_____

City, State, ZIP (+4)_____

E-Mail Address_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Primary Care Physician / Referring Provider Name_____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth____/____/____ Insured's Social Security Number ____-____-____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth____/____/____ Insured's Social Security Number ____-____-____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ *Date*_____

Financial Policy

FLORIDA HEART & VASCULAR CARE Of Broward

As your physician(s), we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

You will be required at each visit to present the office with your insurance card. You are also expected to notify us of any changes in name, address, phone or insurance information. Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments and any deductible required at the time of visit.

Unless arrangements have been made in advance, **co-payments, co-insurance and any outstanding balances are expected at the time of service**. Patients may be financially responsible for payment of all services, even if their insurance company does not pay. Patient accounts not paid promptly are subject to third party collections or legal procedures.

If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor. Patient accounts not paid promptly are subject to third party collections or legal procedures.

We are participating Medicare providers and we will file Medicare for you. We request that any service routinely not covered by Medicare (i.e., Preventative Exams) be paid at the time of service. We request payment for 20% of allowable Medicare charges and any deductible (if applicable) that has not been met a the time of your visit.

If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company.

We also do not accept Letters Of Protection on an auto liability case. We do not participate in the treatment of illnesses in Worker's Compensation claims.

Any check returned from the bank will result in an additional ($20) charge that will appear on your account.

We must emphasize that our concern is with you and your health, not with your insurance company. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in the management of your account.

If at any time you have any unanswered questions or concerns, please feel free to address those issues directly with our Office Manager.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: *Will the protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the authorized for Research Form. If no, proceed to section B.*

FLORIDA HEART & VASCULAR CARE Of Broward

SECTION B: *Required if all Authorizations for Release of PHI or Right to Access*

Patient Name	Date of Birth	Soc. Security # *(optional)*
Patient Address	Requestors Name & Phone # *(if patient is not the requestor)*	

PHI Recipient Name:	Address/City/State/Zip	Phone#
		Fax#
PHI Sender Name:	Address/City/State/Zip	Phone# (954) 475-9535
Florida Heart & Vascular Care	350 NW 84th Ave., Suite 300 • Plantation, FL 33324	Fax# (954) 475-4637

This authorization will expire on the following: (Fill in the Date or Event, but not both.)

Date: Event:

Purpose of Disclosure:

Is this request for psychotherapy notes?

- ❑ Yes, then this is the only item you may request on this authorization.
- ❑ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
❑ All PHI in record		❑ Physician Orders		❑ Demographics	
❑ History & Physical		❑ Laboratory		❑ Rehabilitation Services	
❑ Consult Report		❑ Imaging/Radiology		❑ Special Test Therapy	
❑ Operative Report		❑ Nursing Notes		❑ Itemized Bill Claims	
❑ Progress Notes		❑ Medication Records		❑ Other	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information_____(Initial). If not applicable, check here: ❑

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requestor or the receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

SECTION C: SIGNATURES

I have read the above and authorized the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

Patient Consent Form

FLORIDA HEART & VASCULAR CARE Of Broward

(please read and sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Florida Heart and Vascular Care** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Florida Heart and Vascular Care** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

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

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Florida Heart and Vascular Care.**

I acknowledge that I have been given the **Florida Heart and Vascular Care** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial: _____

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

_____

Patient (or Responsible Party) Signature Date

FLORIDA HEART & VASCULAR CARE Of Broward

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name:_____ DATE:_____

Phone Number:_____ Medicare ID: _____ DOB:_____

PART I:

1) Are you covered by an HMO Plan? ❑ YES ❑ NO If yes, name of HMO:_____

If yes, obtain new insurance information and register appropriately.

PART II: AGENCY RELATED

Date Benefits Began:_____

2) Is the illness or injury covered by:
   - A) The Black Lung Program ❑ YES ❑ NO
   - B) Government Program Such as a research grant? ❑ YES ❑ NO
   - C) Has the Department of Veterans Affairs authorized and Agree to pay for care at this facility? ❑ YES ❑ NO

If yes, Medicare is not primary. MUST BILL APPROPRIATE INSURANCE AGENCY. Complete Part VII.

PART III:

3) Was the illness/injury due to a work related accident/condition? ❑ YES ❑ NO
4) Was the illness/injury due to a non-work related accident/condition? ❑ YES ❑ NO
5) What type of accident caused the illness/Injury? _____
   Non-Automobile? ❑ YES ❑ NO
6) Was another party responsible for the accident:_____

IF ANY OF THE ANSWERS IN PART III IS YES, COMPLETE THE FOLLOWING INFORMATION. IF NO,GO TO PART IV

Date of Accident/Illness/Injury:____/____/____ Insurance Company Name (W/C, Auto, Liability):_____

Insurance Company Address:_____

Insurance Company Phone Number:_____ Policy/Claim/Identification Number:_____

PART IV: ESRD (End Stage Renal Disease) Related (Kidney)

7) Do you have group health plan coverage (GHP)? ❑ YES ❑ NO
8) Have you received a Kidney Transplant? ❑ YES ❑ NO
9) Have you received maintenance dialysis treatment? ❑ YES ❑ NO
10) Have you participated in a self dialysis program? ❑ YES ❑ NO
    If you have participated in a self dialysis program, provide date training started: _____
11) Are you within the thirty month coordination period? ❑ YES ❑ NO If No, Medicare is primary.
12) Are you entitled to Medicare on the basis of either ESRD and Age or ESRD disability? ❑ YES ❑ NO
13) Was your initial entitlement to Medicare based on ESRD? ❑ YES ❑ NO
14) Does the working aged or disability MSP provision apply? ❑ YES ❑ NO

PART V: AGE

15) Are you currently employed? ❑ YES ❑ NO
16) Is your spouse currently employed? ❑ YES ❑ NO
17) Do you have GHP coverage based on your own or a spouse's current employment? ❑ YES ❑ NO
18) Are you covered under a group health plan from an employer with more than 20 employees? ❑ YES ❑ NO

PART VI: DISABILITY

19) Are you currently employed? ❑ YES ❑ NO
    If no, date of retirement:_____
20) Is a family member currently employed? ❑ YES ❑ NO
21) Do you have GHP coverage based on your own or a family member's employment? ❑ YES ❑ NO
22) Are you disabled and covered under GHP from an employer with more than 100 employees? ❑ YES ❑ NO

IF THE ANSWERS TO ANY QUESTIONS IN PART V OR VI IS YES, COMPLETE PART VII:

PART VII:

Patient's Employer Name and Address: _____

Spouse's Employer Name and Address:_____

Name of Policy Holder: _____

Family Member's Employer Name and Address:_____

Relationship to Patient: _____

Patient Policy ID Number:_____ Name of Policy Holder:_____

Spouse/Family Member Policy ID Number:_____ Name of Policy Holder:_____

Name and Address of Group Health Plan: _____

Patient Group ID #:_____ Spouse Group ID #:_____ Family Group ID #: _____

Group ID Number:_____

PATIENT'S SIGNATURE: _____ WITNESS SIGNATURE: _____ DATE: _____