South Tampa Cardiology
ADVANCED IMAGING CENTER

3704 W. EUCLID AVENUE
TAMPA, FL 33629
PH: 813-870-1747 FX: 813-343-6089

PRIVACY PRACTICE-HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

You consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- ¿ Protected health information may be disclosed or used for treatment, payment, or health care operations
- ¿ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- ¿ The Practice reserves the right to change the Notice of Privacy Policies
- ¿ The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- ¿ The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- ¿ The Practice may condition treatment upon the execution of this Consent.

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PATIENT INFORMATION

First Name: _____M.I.: _____ Last Name: _____

Home Address: _____ City: _____ State: _____

Zip Code: _____ Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Age: _____ Marital Status: Single Married Partnered Divorced Other
(Circle One)

Email: _____ SSN: _____

Patients Employer: _____ Occupation: _____

Work Number: _____ Work Address: _____

Emergency Contact/Relation: _____ Phone Number: _____

Preferred Pharmacy/Address: _____ Phone: _____

INSURANCE INFORMATION

Primary Policy Name: _____ ID Number: _____

Group Number: _____ Primary Policy Holder: Self Spouse Parent
(Circle One)

Primary Policy Holder's Name: _____ Date of Birth: _____

Secondary Policy Name: _____ ID Number: _____

Group Number: _____ Secondary Policy Holder: Self Spouse Parent
(Circle One)

Secondary Policy Holder's Name: _____ Date of Birth: _____

Tertiary Policy Name: _____ ID Number: _____

Group Number: _____ Tertiary Policy Holder: Self Spouse Parent
(Circle One)

Tertiary Policy Holder's Name: _____ Date of Birth: _____

ACKNOWLEGDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE- (HIPAA)

I acknowledge and agree that I have received a copy of South Tampa Cardiology's Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name of Legal Representative: _____ Relationship: _____

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Reason for today's visit? (Why are you here?): _____

_____

PATIENT HISTORY FORM

PATIENT CARE TEAM- List all doctors providing care

Doctor's Name	Type of Doctor (Primary Care, Urologist, etc.)	Phone Number	Fax Number

ALLERGIES **Do you have allergies to drugs, food, latex, dye? (circle one)** **YES** **NO**

Allergy- list medication, food, latex, dye (contrast), etc.	Reaction- rash, shortness of breath, hives, itching, etc.	Severity (circle one)
		HIGH MODERATE LOW
		HIGH MODERATE LOW
		HIGH MODERATE LOW
		HIGH MODERATE LOW
		HIGH MODERATE LOW
		HIGH MODERATE LOW
		HIGH MODERATE LOW

MEDICATIONS **Please list all prescription medications, over-the-counter medications, and vitamins. (Bring in medication bottles for further clarity)**

Medication Name (full name from bottle)	Dosage/Strength (mg, mcg, ml etc.)	How often do you take it? (Daily, twice daily, etc.)	How long have you taken? (1 month, 2 years, etc.)	Prescribing Doctor?

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REVIEW OF SYSTEMS Circle symptoms you are experiencing OR circle "no symptoms"

General
- No Symptoms
- Recent Fever
- Chills
- Night Sweats
- Recent weight loss/gain
- Loss of energy

Integumentary (Skin)
- No Symptoms
- Rashes
- Changes in hair or nails
- Breast Lumps
- Breast Biopsy

Eyes
- No Symptoms
- Blind Spots
- Double Vision
- Recent change in vision

Hematological
- No Symptoms
- Excessive bleeding
- Easy bruising

Psychiatric
- No Symptoms
- Depression
- Anxiety
- Substance Abuse
- Change in cognitive function

Respiratory
- No Symptoms
- Recent Cough
- Wheezing
- Pain when breathing
- Excessive sputum
- Shortness of breath

Cardiovascular
- No Symptoms
- Chest pain
- Shortness of Breath
- Leg Swelling
- Heart murmur
- Palpitations

Abdominal
- No Symptoms
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain/Cramping
- Blood in stools
- Pain with food

Genitourinary
- No Symptoms
- Burning on urination
- Bloody urine
- Difficulty urinating
- Urination at night:
  #of times _____
- Difficulty with erections

Musculoskeletal
- No Symptoms
- Unusual muscle aches
- Arthritis
- Back problems

Neurological
- No Symptoms
- Headaches
- Dizziness/off balance
- Stroke
- Weakness
- Numbness

Ear, Nose, and Throat
- No Symptoms
- Recent Hearing loss
- Ringing in ears
- Sore throat
- Difficulty swallowing
- Nasal Congestion
- Nose bleeds
- Visual changes

Endocrine
- No Symptoms
- Goiter
- Excessive thirst
- Increased Urination
- Unexplained changes in weight

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PAST MEDICAL HISTORY

Circle your history/diagnoses

Current/Past Illnesses

Asthma
Bronchitis/Emphysema/COPD
Cancer: _____
Diabetes
Kidney stones/kidney failure
Liver/Gallbladder
Peptic Ulcer-GERD
Prostate
Rheumatic Fever
Seizures
Sleep Apnea
Stroke/CVA
Thyroid Disease
Other_____
_____

Infectious Disease History
_____
_____

Trauma History
_____
_____

Current/Past Cardiac Illnesses

Angina/Chest Pain
Atrial Fibrillation
Congestive Heart Failure (CHF)
Coronary Artery Disease
Heart Attack (MI)
Heart Disease
High Blood Pressure
High Cholesterol
Irregular Heartbeat (Arrhythmias)
Peripheral Vascular Disease
Valvular Heart Disease

Cardiac Risk Factors

History of tobacco use
History of Alcohol Abuse
History of Obesity
Sedentary Lifestyle
Age (male over 45/female over 55)
Menopausal Female

Past Surgeries/Procedures and year done

Appendectomy _____
Back Surgery _____
Cataract Surgery _____
Gallbladder _____
Hernia-Hiatal/Inguinal _____
Hip Surgery _____
Hysterectomy _____
Intestinal _____
Knee Surgery _____
Prostate Surgery _____
Tonsils/Adenoids _____
Cosmetic Surgery _____
Shoulder Surgery _____
Other _____
_____
_____

Past Cardiac Surgeries/Procedures and year done

Cardiac Cath _____
Cardioversion _____
Coronary Angioplasty/Stent _____
Coronary Artery Bypass _____
EP Study _____
ICD _____
Pacemaker Implant _____
RF Ablation _____

Alcohol Use

YES NO Do you consume alcohol?
Average number per week:
_____ beer _____ wine _____ liquor

Smoking/Tobacco Use

YES NO Do you smoke or use tobacco?
YES NO Do you use e-cigarettes/vape?
YES NO Have you smoked in the past?
_____ Number of years? _____Packs per day?
_____Year quit?

Diet

YES NO Are you on a special diet?
What type of diet? _____
YES NO Do you drink caffeinated beverages?
(coffee, tea, cola, etc.)
How many daily? _____

Exercise

YES NO Do you exercise on a regular basis?
(Minimum 30 minutes/3 times a week)

Substance Abuse

YES NO Do you have history of drug dependency?
If yes, specify: _____

Occupation _____

____ Retired ____ Unemployed ____ Student

Residence (patient lives…)(check one)

____ Alone ____ with children ____with parents
____with spouse ____ with spouse & children
____with male partner ____ with female partner
____ in nursing home ____ in assisted living facility

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FAMILY HISTORY (Please check all that apply)

FATHER

____ Alive
____ Deceased
At age _____

____ Heart attack before age 60
____Stroke
____Sudden cardiac death
Other History _____
_____
_____

MOTHER

____ Alive
____ Deceased
At age _____

____ Heart attack before age 60
____Stroke
____Sudden cardiac death
Other History _____
_____
_____

Sibling(s)

_____ Number of Brother(s)
#____ Alive
#____ Deceased
At age _____
At age _____
At age _____

____ Heart attack before age 60
____Stroke
____Sudden cardiac death
Other History _____
_____
_____

_____ Number of Sister(s)
#____ Alive
#____ Deceased
At age _____
At age _____
At age _____

____ Heart attack before age 60
____Stroke
____Sudden cardiac death
Other History _____
_____
_____

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South Tampa Cardiology LLC

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, to be paid to South Tampa Cardiology, LLC. I authorize the sending of all medical information needed to secure payment. Copies of these records can be mailed, faxed, or transmitted electronically via secure sites. This assignment will remain in effect until revoked in writing. I further permit a copy of this authorization to be used in place of the original.

I fully understand that I am financially responsible for all amounts not otherwise paid by my insurance carrier. (**This includes annual deductibles, co-payments, and charges denied as not covered by my insurance program.)** Account balance are to be paid in full within 30 days of receiving a statement. I understand accounts become delinquent 90 days following date of service and these charges may be assigned to a collection agency.

Insurance Patients: Billing your insurance is a courtesy we are happy to provide you. If the insurance does not respond you will become responsible. All co-pays and deductibles are dure in full at time of service. If you are unable to pay your deductible in full, you will need to meet with the billing department to set up a payment plan. If no insurance card is presented upon arrival, you will be considered self-pay.

Uninsured Patients: A 15% discount will be offered to you if you pay in full at time of service. Prior to your appointment, arrangements for payment will need to be established.

Authorizations: Please call your insurance to obtain insurance requirements for your visit or testing. Failure to obtain necessary pre-authorization or notification may result in a reduction or rejection of benefits by the insurance company.

Missed appointment fee: If you miss your appointment, or you cancel with less that 24-hour notice, these may be a $25.00 missed appointment fee charged. Please call us 24hours prior to your appointment to cancel or reschedule.

Returned Check: There is a fee (currently $25.00) for any checks returned by the bank.

Confidential information expressly identifies the medical nature of the services rendered. It includes all information and records in the course of treatment. I authorize South Tampa Cardiology, LLC to send copies of my records to my referring physician, primary care doctor, or other medical care providers for treatment purposes. Copies o these records can be mailed, faxed, or transmitted electronically via secure sites.

I HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND HAVE RECEIVED A COPY UPON MY REQUEST. I ACCEPT RESPONSIBILITY OF ITS TERMS.

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____

If someone other that the patient is signing the authorization, please state the relationship to the patient and the reason why the patient is unable to sign.

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Records Release Authorization

Date: _____

Requesting Records from Dr(s): _____

_____

Type of Records Needed: _____

I hereby authorize you to release my medical records to:

South Tampa Cardiology, LLC
Cesar Alberto Morales-Pabon MD
3704 W. Euclid Avenue
Tampa, FL 33629
Phone: 813-870-1747
Fax: 813-343-6089

Printed Name: _____

Date of Birth: _____

Signature: _____

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Family Authorization Form

In compliance with HIPAA regulations, *South Tampa Cardiology* want to protect your privacy health information. Please list below the names of the people that you authorize our staff and providers to talk to about your health and medical information.

Name	Relationship	Phone Number

_____ _____

Patient Signature Date