HEARTSPECIALISTS OF SARASOTA

David M. Yamada, MD, FACC, FSCAI
Michael Mollod, MD, FACC
Robert E. Eckart, DO, FACC, FHRS
Brian P. Betensky, MD, FACC, FHRS
Anthony W. D'Souza, MD
Evan M. Caruso, MD
V. Grant Luce, PA-C
Keith Sieracki, PA-
Marty Kent, PA-C
David Schreibman, MD, FACC
Steven J. Class, MD, FACC
Chippy Ajithan, MD, FACC
Garrett H. Brown, MD
Daniel L. Molloy, MD
Thomas P. Archer, MD
Matthew Johnson, PA-C
Andrea Haynie, ARNP

WELCOME TO HEART SPECIALISTS OF SARASOTA

We appreciate you choosing our practice for your heart health treatment. We will do all that we can to be sure that your care is provided on a timely, pleasant basis and that all your questions are answered before you leave our office. Please be sure to bring your current insurance cards when you come for your appointment. Co-payments are expected at the time of service.

HMO, MANAGED CARE AND PPO PLANS

If you are enrolled in an HMO, you will probably need to have a referral from your Primary Care Physician (PCP) to see one of our specialists. Please be sure that the referral has been issued to our office by your PCP. **If services are rendered without a referral you will be responsible.** Managed Care health plans, including Medicare Advantage/Replacement plans, will require authorizations from your insurance company for tests and for surgical procedures. If we have difficulty getting authorizations, your services may be cancelled.

OUR BILLING PROCESS

Heart Specialists of Sarasota participates with most major health insurance companies, including Medicare. As long as we participate with your health carrier, we will bill them directly. You are responsible for contacting your health plan to determine if we are in their Provider Network. Copayments required by your health plan, as well as any outstanding balances, will be collected at the time of service.

If you do not provide us with correct insurance information and your claims are denied, you will be required to pay for any services you received. You will be responsible for all balances that remain after your health plan pays, such as deductibles, coinsurance and noncovered services. If you have secondary coverage, Heart Specialists of Sarasota will bill the secondary carrier. **You must let us know right away if your insurance plan changes at any point in time, to ensure that accurate claims are submitted to the correct health plan.**

1950 Arlington St, Suite 400
Sarasota, FL 34239
Phone: (941) 917-4250 Fax: (941) 917-4257

After all payments are received from your health plans, you will be billed for all remaining balances. If you have no health insurance, a prompt payment discount will be considered when paying at the time that your services are rendered.

Statements are sent to patients at the end of the month. The statement will indicate how much you owe. Payment is due upon receipt to avoid further collection activity. Balances not paid after 60 days will incur finance charges at the rate of 2% per month.

RETURNED CHECK FEES

A **$35.00** service charge will be added to your account for any returned check.

MISSED APPOINTMENTS

Note: Missed appointments, without 24 hour prior notification, will be subject to a $25.00 fee. Missed Nuclear testing appointments, without 24 hour prior notice, will be subject to a $150.00 fee. We understand that you may need to reschedule an appointment. By providing 24 hour prior notification we are able to fill that time slot with another patient who is in need of services.

Please note that our ultimate goal at Heart Specialists of Sarasota is to assist in establishing a payment methodology that works best to help you to satisfy your financial obligation to your physician, while preventing outside collections. **Please** discuss any payment concerns you may have with our front desk receptionists.

Thank you for your consideration.

Please sign below to acknowledge your receipt and understanding of our financial/payment policies,

Patient Signature:_____

Date:_____

1950 Arlington St, Suite 400
Sarasota, FL 34239
Phone: (941) 917-4250 Fax: (941) 917-4257

Notice of Privacy Practices
For
Heart Specialists of Sarasota

This notice describes how medical information about you may be used and disclosed, how you can get access to this information, and your rights and our responsibilities. Please review it carefully.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, your future treatment plan, and your billing information. This notice applies to all of the records that are generated by our physicians.

Our Responsibilities

At Heart Specialists of Sarasota (HSS) we are committed to maintaining the privacy of your protected health information. We are required by law to provide you with this notice of our legal duties and privacy practices. Additionally, we are required to notify affected individuals if there is ever a breach of any unsecured protected health information. We will abide by the notice that is currently in effect. **This notice is effective 7/1/13.**

Uses and Disclosures – How we may use and disclose protected health information about you.

For Treatment: We may use protected health information about you, in paper or electronic form, to provide you with treatment or services. We may disclose protected health information about you to other health care providers. For example, we may need to communicate with your primary care physician (PCP) concerning your treatment plan and follow up care.

For Payment: We may use and disclose protected health information about your treatment and services to our billing office, to seek payment from your insurance company or other third party payer or family member who assumes financial responsibility for your care. For example, we may need to give your insurance company information about your diagnosis in order to obtain an authorization so services will be paid.

For Healthcare Operations: We may use and disclose your protected health information in order to improve our practice. For example, medical staff and/or others involved in quality improvement may review your care and treatment outcome as a basis for continually improving quality of care for all.

We also use and disclose protected health information:

- To business associates we contract with to perform services related to your care;
- To remind you that you have an appointment, give you test results or tell you of treatment alternatives;
- To assess your satisfaction with the services we provide to you;
- To discuss care coordination or prescription refills with you or your pharmacy;
- When conducting training programs for healthcare professionals.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release protected health information about you to family members, friends or others involved in your care.

Research: We may disclose information to researchers when they offer services that may be beneficial to you based on your diagnoses, as long as there is no payment made to us for the disclosure.

Future Communications:

As Required by Law, for example, we may disclose your protected health information to the following:

- Government agencies, such as Public Health, or legal or federal authorities responsible for preventing or controlling disease, injury, disability, or other threat to health, safety or national security.
- Workers compensation agents
- Law enforcement for purposes as required by law or in response to a valid subpoena or court order
- Correctional institutions if you are in custody of a correctional institution or law enforcement officer.

Other Uses of Your Protected Health Information That Require Your Authorization

- Psychotherapy notes, if any, may not be released without your authorization.
- Release of your protected health information for marketing purposes requires your authorization.
- The sale of any of your protected health information is prohibited without your authorization.
- You may opt out of any fund raising activities on a per solicitation basis.
- Any other use or disclosure not described in this notice would require your authorization.

If you provide authorization for any of the above, you may revoke that permission at any point in time and from that day forward, we will no long use or disclose your protected health information for the reasons covered by your authorization. You understand that we are not able to take back any disclosures that were already made with your permission.

Your Health Information Rights

Although your health record is the physical property of Heart Specialists of Sarasota, you have the right to:

- Inspect and copy your protected health information. You may request access to your records on paper or in electronic form, by contacting us. You may also ask that we send your health information directly to another individual with your signed, written instructions. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records. We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.
- Request an amendment to your protected health information, in writing with a detailed explanation, if you believe that the information we have is incorrect or incomplete. If for some reason your request is denied, you will be notified in writing of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information other than treatment, payment, healthcare operations, or other permitted uses.
- Notification of a breach of unsecured protected health information, as required following a risk assessment, including any steps that you need to take in order to protect yourself against harm due to the breach.
- Request, in writing, that we restrict communication to your health plan regarding a specific treatment or service, as long as is it not required by law, and you, or someone you know, has paid for the service in full. Effective March 26, 2013, The Omnibus Rule requires that we honor this restriction.
- Request confidential communications. You have the right to alternative means of communication as long as it is reasonable and made in writing, with the alternative means listed. For example, you may ask that we contact you at work or by US postal service. The request should include an address where you would like to receive bills and related correspondence regarding payment for services.
- A paper copy of this notice. You may ask for a copy of this notice at any point in time. You may obtain a copy of this notice on our website: www.heartspecialistsofsarasota.com.

Changes to This Notice: We reserve the right to change this notice. The current notice will always be posted in our office and will include the new effective date. Copies of any revised notices will be available on our website. You may also receive a copy from our office upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer, Christine Archambault at 941-225-6006, or by contacting the Office for Civil Rights as noted below:

Office for Civil Rights
US Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

HEARTSPECIALISTS OF SARASOTA

FLORIDA PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider. As a patient, the following is a summary of your rights and responsibilities:

YOUR RIGHTS

- You have the right to be treated with courtesy and respect, with appreciation of your individual dignity, and with the protection of your need for privacy.
- You have the right to a prompt and reasonable response to questions and requests.
- You have the right to know who is providing medical services and who is responsible for your care.
- You have the right to know what patient support services are available, including whether an interpreter is available if you do not speak English.
- You have the right to know what rules and regulations apply to your conduct.
- You have the right to be given your diagnosis, planned course of treatment, alternatives, risks, and prognosis by the health care provider.
- You have the right to refuse any treatment, except as otherwise provided by law.
- You have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your health care.
- If you are eligible for Medicare, you have the right to know, upon request and in advance of treatment, whether the health care provider accepts the Medicare assignment rate.
- You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- You have the right to receive a copy of a reasonably clear and understandable, itemized bill, and upon request, to have the charges explained.
- You have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- You have the right to treatment of any emergency medical condition that will deteriorate from failure to provide treatment.
- You have the right to know if your treatment is for the purpose of experimental research and to give your consent or refusal to participate in such experimental research.
- You have the right to express grievances regarding any violation of you rights as stated in Florida Law, through the grievance procedure of the health care provider that served you and through the appropriate state licensing agency.

Main Office
1950 Arlington St, Suite 400
Sarasota, FL 34239

Phone: (941) 917-4250 Fax: (941) 917-4257

YOUR RESPONSIBILITIES

- You are responsible for providing to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- You are responsible for reporting unexpected changes in your condition to the health care provider.
- You are responsible for reporting to the health care provider whether you comprehend a contemplated course of treatment and what is expected of you.
- You are responsible for following the treatment plan recommended by the health care provider
- You are responsible for keeping appointments and, when you are unable to do so for any reason, for notifying the health care provider.
- You are responsible for your actions if you refuse treatment or do not follow the health care provider's instructions.
- You are responsible for assuring that the financial obligations of your health care provider are fulfilled as promptly as possible.
- You are responsible for following established rules and regulations affecting patient care and conduct.

In addition to the above, you are responsible for treating the health care provider, their employees and other patients within the facility with the same courtesy and respect, and appreciation of his or her individual dignity, and with the protection of his or her need for privacy as you are entitled to.

Main Office
1950 Arlington St, Suite 400
Sarasota, FL 34239

Phone: (941) 917-4250 Fax: (941) 917-4257

HEARTSPECIALISTS OF SARASOTA

David M. Yamada, MD, FACC, FSCAI
Michael Mollod, MD, FACC
Robert E. Eckart, DO, FACC, FHRS
Brian P. Betensky, MD, FACC, FHRS
Anthony W. D'Souza, MD
Evan M. Caruso, MD
V. Grant Luce, PA-C
Keith Sieracki, PA-
Marty Kent, PA-C
David Schreibman, MD, FACC
Steven J. Class, MD, FACC
Chippy Ajithan, MD, FACC
Garrett H. Brown, MD
Daniel L. Molloy, MD
Thomas P. Archer, MD
Matthew Johnson, PA-C
Andrea Haynie, ARNP

MEDICARE LIFETIME SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Heart Specialists of Sarasota, PL for any services furnished by the group. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information necessary to determine these benefits payable for related services.

Authorized Signature:_____ Date:_____

PERMISSION FOR TREATMENT/AUTHORIZATION/FINANCIAL RESPONSIBILITIES/FAX

- Permission is hereby granted for the physicians, employees, or agents of Heart Specialists of Sarasota, PL to render such medical and surgical treatment as is deemed necessary.
- As part of my treatment, the practitioners/physicians at Heart Specialists of Sarasota, PL may prescribe testing or other procedures to be performed here. I understand that the physicians are owners and I have been advised that. According to Florida laws, I am under no obligations to use this facility.
- In consideration of the services rendered to the patient, I agree to accept full financial responsibility for the patient's account in accordance with the regulate rates and terms of the practice. Co-pays and deductibles are due at the time of services. Should the account be referred for collections procedures, I shall pay reasonable attorney's fees and collection expenses. Heart Specialists of Sarasota, PL is authorized to act as my agent to help me assure payment from my insurances.
- I authorize my insurance company to pay and hereby assign to Heart Specialists of Sarasota, PL, all benefits otherwise payable to me for services *as described on the attached form.*
- The undersigned authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered and services to be rendered without obtaining my signature on each and every claims to be submitted for myself and/or my dependents and that I will be bound by this signature as though I had personally signed the particular claim.
- My signature below also serves as authorization to release information from my medical record to my referring physician, primary care physician, and/or hospital for the purpose of continuing care.
- The patient's medical records are regarded in the strictest confidence however, there may be a time when faxing records may expedite care. I permit Heart Specialists to fax medical records for me or my dependents.

Authorized Signature:_____ Date:_____

1950 Arlington St, Suite 400
Sarasota, FL 34239
Phone: (941) 917-4250 Fax: (941) 917-4257

HEART SPECIALISTS OF SARASOTA

HIPAA Acknowledgement

I understand that as part of my health care, Heart Specialists of Sarasota, PL 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 and have been provided with a *Notice of Privacy Policies* (Notice) that gives a more complete description of information uses and disclosures.

I understand that Heart Specialists of Sarasota, PL is not required to agree to restrictions requested. I understand that I may revoke my permission in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that Heart Specialists of Sarasota, PL reserves the right to change their notice and policies, in accordance with Section 164.520 of the Code of Federal Regulations. A copy of our current Notice, including future revisions will be posted in our waiting room and is available upon request.

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 phone, fax, text or email.

I authorize Heart Specialists of Sarasota, PL to release information about my appointments, billing and /or financial information and medical information to the following individuals:

Name:_____Relationship:_____Tel#:_____

Name:_____Relationship:_____Tel#:_____

Name:_____Relationship:_____Tel#:_____

This list may not be all inclusive and I recognize that my healthcare providers may have to use their best judgment in some instances where they communicate to others involved in my care.

Additionally, I authorize Heart Specialists of Sarasota, PL to leave information concerning my appointments (including pre-recorded messages), billing or financial information, and medical information on my answering machine/voice mail at the phone number(s), including wireless telephone numbers, which I have provided. I understand that receiving information regarding my health can be delayed if messages can not be left.

I understand that in order to revoke the authorizations above (except to the extent that the organization has already taken action), I must request this revocation in writing to the Privacy Officer and that until such written documentation is received, this authorization will be followed.

_____ _____

Patient Signature Date

HEART SPECIALISTS OF SARASOTA

David M. Yamada, MD, FACC, FSCAI
Michael Mollod, MD, FACC
Robert E. Eckart, DO, FACC, FHRS
Brian P. Betensky, MD, FACC, FHRS
Anthony W. D'Souza, MD
Evan M. Caruso, MD
V. Grant Luce, PA-C
Keith Sieracki, PA-
Marty Kent, PA-C
David Schreibman, MD, FACC
Steven J. Class, MD, FACC
Chippy Ajithan, MD, FACC
Garrett H. Brown, MD
Daniel L. Molloy, MD
Thomas P. Archer, MD
Matthew Johnson, PA-C
Andrea Haynie, ARNP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I confirm that I have received the Heart Specialists of Sarasota Notice of Privacy Practices.

_____

Patient Name (Printed)

_____ _____

Signature Date

If signed by patient representative, please indicate relationship:_____

_____

_____

For Office Use Only

We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ The Patient refused to sign

□ An emergency situation prevented us from obtaining acknowledgement.

□ Other: _____

_____ Initials _____

1950 Arlington St, Suite 400
Sarasota, FL 34239
Phone: (941) 917-4250 Fax: (941) 917-4257

HEARTSPECIALISTS OF SARASOTA

David M. Yamada, MD, FACC, FSCAI
Michael Mollod, MD, FACC
Robert E. Eckart, DO, FACC, FHRS
Brian P. Betensky, MD, FACC, FHRS
Anthony W. D'Souza, MD
Evan M. Caruso, MD
V. Grant Luce, PA-C
Keith Sieracki, PA-
Marty Kent, PA-C
David Schreibman, MD, FACC
Steven J. Class, MD, FACC
Chippy Ajithan, MD, FACC
Garrett H. Brown, MD
Daniel L. Molloy, MD
Thomas P. Archer, MD
Matthew Johnson, PA-C
Andrea Haynie, ARNP

In order to provide quality care, Heart Specialists of Sarasota (HSS) would like access to your prescription information. Knowing what medications are prescribed to you by other providers and which medications are preferred by your insurance company will help us coordinate a treatment plan that is best for you. With your permission we can do this automatically through your Pharmacy Benefit Manager (PBM).

Please select one of the following:

☐ YES, I give consent for HSS to access prescription information from my PBM, including non HSS providers.

☐ Physician ONLY – Consent is granted, but only for medications prescribed by HSS.

☐ NO, I will not allow information to be retrieved from by PBM.

_____ _____

(Patient Name) (Date of Birth)

_____ _____

(Signature) (Date Signed)

_____

(Printed Name if other than patient)

☐ ***I am the guardian or legal representative signing on behalf of this patient and documentation has been provided by the office.***

1950 Arlington St, Suite 400
Sarasota, FL 34239
Phone: (941) 917-4250 Fax: (941) 917-4257

HEART SPECIALISTS OF SARASOTA, PL
NEW PATIENT INFORMATION

PLEASE COMPLETE ALL PAGES IN FULL--PLEASE PRINT

DATE OF VISIT: _____ NAME: _____

SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH: _____ CURRENT AGE: _____

SS:# _____ MARITAL STATUS: ___S ___M ___W

RACE/ETHNICITY: CAUCASIAN ☐ AFRICAN AMERICAN ☐ HISPANIC ☐ NATIVE AMERICAN ☐ ASIAN ☐

LOCAL ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ How should we notify you of your appointments? ☐ Phone ☐ Text ☐ Email

HOME TEL #(_____)_____ WORK #(_____)_____ CELL #(_____)_____

E-MAIL ADDRESS: _____ FAX NUMBER: (_____)_____

NORTHERN ADDRESS: _____ CITY: _____ ST _____ ZIP _____

NORTHERN TEL #: (_____)_____ EXPECTED RETURN DATE: _____

EMPLOYER: _____ EMPLOYER PHONE#: (_____)_____

EMPLOYER ADDRESS: _____

*EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE# (_____)_____

****

INSURANCE INFORMATION:

PRIMARY: _____ ID # _____ GRP# _____

POLICY HOLDER: _____ POLICY HOLDER'S DOB: _____

POLICY HOLDER'S SS# _____ POLICY HOLDER'S EMPLOYER: _____

SECONDARY: _____ ID # _____ GRP# _____

POLICY HOLDER: _____ POLICY HOLDER'S DOB: _____

POLICY HOLDER'S SS# _____ POLICY HOLDER'S EMPLOYER: _____

WHO REFERRED YOU TO US? REFERRED BY _____ SELF REFERRED _____

PRIMARY CARE PHYSICIAN: _____ TEL _____ FAX _____

OTHER PHYSICIANS YOU SEE:

NAME: _____ TEL (_____)_____ FAX (_____)_____

NAME: _____ TEL (_____)_____ FAX (_____)_____

NAME: _____ TEL (_____)_____ FAX (_____)_____

HEARTSPECIALISTS OF SARASOTA

PATIENT QUESTIONNAIRE:

NAME: _____ **DOB:** _____ **DATE:** _____

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:** _____

REASON FOR VISIT: _____

RISK FACTORS:

	YES	NO
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
DIABETES		
PREMATURE HEART DISEASE IN THE FAMILY:		
1) 1ST DEGREE MALE (FATHER/BROTHER/SON) < 55yo WITH HISTORY OF HEART ATTACK, BYPASS SURGERY OR STENT.		
2) 1ST DEGREE FEMALE (MOTHER/SISTER/DAUGHTER) < 65yo WITH HISTORY OF HEART ATTACK, BYPASS SURGERY OR STENT.		

SOCIAL HISTORY:

	YES	NO
CIGARETTE SMOKING		
* FORMER		
* # PACKS/DAY		
* # YEARS YOU SMOKED		
ALCOHOL USE		

IMMEDIATE FAMILY HISTORY (CHECK ALL THAT APPLY):

MEMBER	ALIVE Y/N	CAUSE AND AGE OF DEATH	CAD	HEART ATTACK	HIGH BLOOD PRESSURE	HEART FAILURE	STROKE	VASCULAR DISEASE	ARRHYTHMIA	SUDDEN DEATH
MOTHER										
FATHER										
SISTER										
SISTER										
SISTER										
BROTHER										
BROTHER										
BROTHER										

HEART SPECIALISTS OF SARASOTA

ARE YOU ALLERGIC TO IODINE OR SHELLFISH? YES NO

LIST ALL DRUG ALLERGIES AND REACTIONS:

MEDICATIONS:

NAME:	DOSE:	FREQUENCY:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

CARDIAC PROCEDURES/YEAR/HOSPITAL (Angioplasty, stents, bypass surgery, valve surgery, defibrillators, pacemakers)

TYPE OF PROCEDURE	DATE	WHERE PERFORMED

MAJOR ILLNESSES AND YEAR(S):

PRIOR SURGERIES AND YEAR(S):

Heart Specialists of Sarasota, PL - Patient Review of Systems

		Yes	No
Constitutional	Weight gain		
	Weight loss		
	Fatigue		
	Fever		
	Night sweats		
Eyes	Double vision		
	Blurred vision		
	Shade over eyes		
HENT	Headaches		
	Room spinning		
	Nose bleeds		
Cardiovascular	Chest pain		
	Palpitations		
	Passing out		
	Shortness of breath with exertion		
	Shortness of breath lying flat		
	Smothering feeling		
	Leg swelling		
	Dizziness		
Respiratory	Shortness of breath		
	Wheezing		
	Cough		
	Coughing blood		
Gastrointestinal	Nausea		
	Vomiting		
	Diarrhea		
	Reflux		
	Excessive belching		
	Abdominal pain		
	Blood in stools		
Genitourinary	Frequent urination		
	Frequent urination at night		
	Blood in urine		
Neurologic	Muscular weakness		
	Tingling or numbness		
	Speech difficulties		
	Visual disturbances		
MSK	Joint pain		
	Joint swelling		
	Muscle pain		
Endocrine	Cold intolerance		
	Heat intolerance		
Heme	Easy bleeding		
	Easy bruising		

HEART SPECIALISTS OF SARASOTA, PL

This questionnaire is to be completed by or on behalf of a patient with Medicare.

1. Is the patient retired? ____Yes ____No ____Never worked

   If yes, Retirement Date:_____

2. Is the patient still covered under a Group Health Plan provided by an employer?

   ____Yes ____No ____Never worked

   If yes: Name of the Health Plan:_____ Eff Date:___/___/___

3. Is the patient's spouse retired? ____Yes ____No ____Never worked or Not Married

   If yes, Retirement Date:_____

4. Is the spouse still covered under a Group Health Plan provided by an employer?

   ____Yes ____No ____Never worked

   If yes: Name of the Health Plan:_____ Eff Date:___/___/___

5. If the patient is divorced or the spouse is deceased, did that happen prior to the patient's Medicare effective date? _____Yes _____No

6. If the patient was divorced or the spouse passed away after the patient's Medicare effective date, what was the date of the event? ____/____/____

7. Is the patient scheduling an appointment to be seen for an illness or injury related to an accident?
   _____Yes _____No

   If yes, please select one of the following: ____Automobile ____Work Related ___Neither

   If work related or an auto accident, what was the date of the accident:____/____/____

   What is the name of the insurance company::_____.

8. Has the patient ever been diagnosed with a Black Lung condition? _____Yes _____No

   If yes, when: ____/_____/_____

HEARTSPECIALISTS OF SARASOTA

David M. Yamada, MD, FACC, FSCAI
Michael Mollod, MD, FACC
Robert E. Eckart, DO, FACC, FHRS
Brian P. Betensky, MD, FACC, FHRS
Anthony W. D'Souza, MD
Evan M. Caruso, MD
V. Grant Luce, PA-C
Keith Sieracki, PA-
Marty Kent, PA-C
David Schreibman, MD, FACC
Steven J. Class, MD, FACC
Chippy Ajithan, MD, FACC
Garrett H. Brown, MD
Daniel L. Molloy, MD
Thomas P. Archer, MD
Matthew Johnson, PA-C
Andrea Haynie, ARNP

Dear Patient,

Our physicians would like to spend as much time as possible with you when you arrive for your schedule visit. One of the ways we can make that happen is to ensure that you are in the exam room or procedure room on time. Delays in completing paperwork in the office can keep us from having our patients ready to see the doctor or have their procedures at their appointed time.

Please make sure that you arrive thirty (30) minutes prior to your appointment time and that you bring your completed paperwork with you. We will also need to see your insurance card(s) and your current medication list at each visit. It is normally easier for our patients to complete their paperwork at home when they have the documents that they need to refer to and/or family member available who can assist them.

We understand that seeking and receiving medical care can be stressful. We pride ourselves in the quality of care that we deliver, our level of communication, and our dedication to our patients. In order to provide a safe, caring, and orderly environment, Heart Specialists of Sarasota expects civility from all patients. Mutual respect, professionalism and common courtesy are expected while we work with you. We reserve the right to end the provider-patient relationship if the staff are treated in a disrespectful or hostile manner, just as you have the right to seek services elsewhere, if you are not satisfied with your care here.

If you are unable to keep your appointment, please provide 24 hour prior notice by calling 941-917-4250, option 1. We will be happy to reschedule your appointment. Missed appointments impact everyone. If we do not receive 24 hour prior notification, a $25.00 charge for the missed appointment will be applied to your account.

Thank you for assisting us in giving you the best care possible.

Sincerely,

Heart Specialists of Sarasota

1950 Arlington St, Suite 400
Sarasota, FL 34239
Phone: (941) 917-4250 Fax: (941) 917-4257

less wait could be good for your heart rate.

Are you on the InterNET?

So are WE!

At **Heart Specialists of Sarasota** our goal is to provide you with the best experience possible when interacting with our practice. That's why we're pleased to offer **secure, interactive patient self-service** features that let you communicate with us from the convenience of your home or office.

With our **Web-based patient portal**, you can simply and securely:

- Fill out registration forms
- Request appointments
- Request prescription renewals
- Ask a nurse a question
- Pay your bill online

Virtually eliminating time on hold or in the waiting room for these types of interactions.

It's fast, it's easy, and it's convenient.

Visit our website for more information and to start using these stress-free features today!

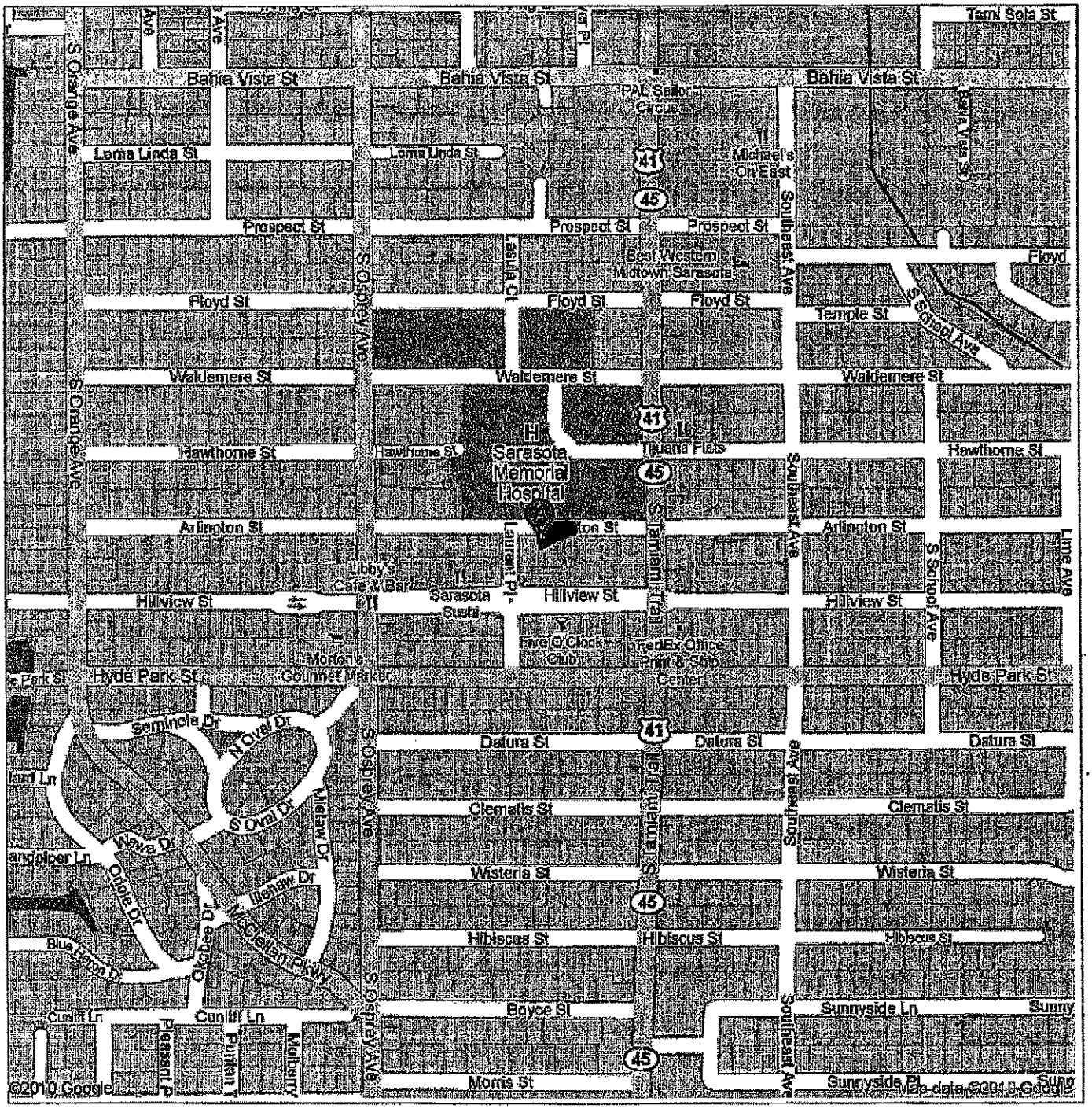
Visit us on Facebook!

www.heartspecialistsofsarasota.com

Google maps

Address **1950 Arlington St**
Sarasota, FL 34239

Notes WE ARE ON THE 4TH FLOOR, SUITE# 400



HEARTSPECIALISTS OF SARASOTA

David M. Yamada, MD, FACC, FSCAI
Michael Mollod, MD, FACC
Robert E. Eckart, DO, FACC, FHRS
Brian P. Betensky, MD, FACC, FHRS
Anthony W. D'Souza, MD
Evan M. Caruso, MD
V. Grant Luce, PA-C
Keith Sieracki, PA-
Marty Kent, PA-C
David Schreibman, MD, FACC
Steven J. Class, MD, FACC
Chippy Ajithan, MD, FACC
Garrett H. Brown, MD
Daniel L. Molloy, MD
Thomas P. Archer, MD
Matthew Johnson, PA-C
Andrea Haynie, ARNP

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

PATIENT:

_____ Name of Patient/Previous Names

_____ Birth Date/Social Security Number

_____ Street Address

_____ City, State, Zip

_____ Telephone Number

AUTHORIZES:

Heart Specialists of Sarasota
1950 Arlington St.
Suite 400
Sarasota, FL 34239
Phone: 941-917-4250
Fax: 941-917-4257

RELEASE OF PROTECTED HEALTH INFORMATION TO:

_____ Name of Health Care Provider

_____ Street Address

_____ City, State, Zip

Phone or Fax:

INFORMATION TO BE RELEASED:

I hereby authorize you to release **all** of my medical records for any treatment and laboratory/diagnostic tests performed **except for**:

___Sexually Transmitted Disease
___HIV (AIDS)
___Alcohol Abuse Treatment
___Drug Abuse Treatment
___ Mental Health Treatment
___ Records from other facilities and providers

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (check one)

___ Further Medical Care
___ Insurance/Eligibility
___ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Heart Specialists of Sarasota will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Heart Specialists of Sarasota will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____

(If signed by other than patient, state relationship and authority to do so.)

EXPIRATION DATE: This authorization is good until the following date(s)_____or for twelve (12) months from the date signed. Distribution of copies: Original to provider; copy to patient; copy to accompany released records

REV. 07/16