Bay Area Cardiology Associates, P.A.
Consultative, Diagnostic & Interventional Cardiology

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Thank you for choosing Bay Area Cardiology Associates, P.A. Enclosed, you will find ***patient registration forms***. Please fill out these forms and bring them with you at the time of your office appointment date: _____ time: _____ at the location below:

❒ Brandon Office
635 Eichenfeld Drive
Brandon, FL 33511
(813) 684-6000

❒ Sun City Office
3920 Galen Court
Sun City Ctr., FL 33573
(*813)684-6000*

❒ Tampa Office
10740 Palm River Rd.
#370
Tampa, FL 33619
(813) 684-6000

❒ Riverview Office
13029 Summerfield Square Dr
Riverview, FL 33578
(*813) 684-6000*

***LOCAL PHARMACY NAME*:** _____

***PHARMACY ADDRESS*:** _____

***PHARMACY TELEPHONE*:** _____

MAIL ORDER PHARMACY NAME: _____

Please bring the following with you:

(1) The patient's insurance or Medicaid card
(2) Authorization or referral if required
(3) All current medications (bottles)

ATTENTION: ***Bay Area Cardiology provides you with the highest quality care. We therefore ask that you bring all related HOSPITAL RECORDS and/or MEDICAL RECORDS i.e., recent LABS, PROCEDURES, SURGERIES or TESTING since your last office visit.***

If you are new to our practice, PLEASE BRING ALL RECORDS PERTAINING to your CARDIAC HISTORY as your appointment may need to be rescheduled without these records.

Please arrive 15 minutes prior to appointment

Thank you for allowing us to assist in your care.

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PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ MI _____

Primary Address: _____ Apt. #_____
(Florida address required, if out-of-state, fill in secondary)

Secondary Address: _____ Alternate Phone: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ **Work Phone**: _____

E-Mail: _____ **REFERRAL SOURCE:** ❒ AD/NEWSPAPER ❒ FRIEND ❒ PCP ❒ HOSP _____ ❒ INTERNET ❒ OTHER: _____

Date of Birth: _____ **Marital Status:** _____ **Social Security:** _____

Sex: _____ **Race/Ethnicity (Optional):** _____

Employer: _____

Spouse's Name: _____ **Spouse's Work**: _____

Spouse's Employer: _____

Emergency Contact: _____ **Number:** _____ **Relationship**: _____

Primary Insurance: _____ Secondary Ins: _____
(Primary Insurance card @ time of office visit to be copied) *(Present insurance card @ time of office visit to be copied)*

Name of Insured: _____ Relationship: _____

Date of Birth: _____ Social Security: # _____

Primary Care Physician: _____
Please have insurance card(s) ready to be copied upon completion of your information sheet.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. INSURANCE AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. If this account should be referred to a collection agency, (I will be responsible for any balances placed with collections). I have read and understand the office policy and procedure.

Driver's License #: _____ State Licensed: _____
Patient Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY

DATE_____ Date of Birth_____

PATIENT NAME:_____ AGE:_____

REFERRED DOCTOR:_____

CHIEF COMPLAINT (reason for visit): _____

_____

If you are here for a test (stress test, echocardiogram, holter monitor, etc.), do you know why it was ordered? _____

PAST MEDICAL HISTORY – 1:

Coronary artery disease IF YES Describe: _____

Heart attack (myocardial infarction) IF YES Describe: _____

Heart valve disease

- Mitral Valve Disorder IF YES Describe: _____
- Aortic Valve Disorder IF YES Describe: _____
- Tricuspid Valve Disorder IF YES Describe: _____
- Pulmonary Valve Disorder IF YES Describe: _____
- Murmur IF YES Describe: _____
- Other heart valve disorders IF YES Describe: _____

Congestive heart failure IF YES Describe: _____

Cardiomyopathy

- Dilated Cardiomyopathy-(Enlarged Weak Heart) IF YES Describe: _____
- Hypertrophic Cardiomyopathy-(Thick Heart) IF YES Describe: _____
- Restrictive Cardiomyopathy IF YES Describe: _____
- Other Cardiomyopathy IF YES Describe: _____

Irregular heart beats

- Atrial Fibrillation (AF) IF YES Describe: _____
- Atrial Flutter (AFL) IF YES Describe: _____

- Supraventricular tachycardia (SVT) IF YES Describe: _____
- Ventricular tachycardia (VT) IF YES Describe: _____
- Sick Sinus Syndrome (SSS) IF YES Describe: _____
- Wolff-Parkinson White Syndrome (WPW) IF YES Describe: _____
- A-V Block IF YES Describe: _____
- Sinus Tachycardia IF YES Describe: _____
- Sinus Bradycardia IF YES Describe: _____
- Right Bundle Branch Block IF YES Describe: _____
- Left Bundle Branch Block IF YES Describe: _____
- Other IF YES Describe: _____

Vascular disease

- Peripheral Artery Disease (PAD) IF YES Describe: _____
- Carotid Artery Stenosis IF YES Describe: _____
- Abdominal Aortic Aneurysm (AAA) IF YES Describe: _____
- Thoracic Aortic Aneurysm (TAA) IF YES Describe: _____
- Varicose vein(s) IF YES Describe: _____
- Venous Insufficiency IF YES Describe: _____
- Deep Vein Thrombosis (DVT) IF YES Describe: _____
- Pulmonary Embolism (PE) IF YES Describe: _____
- Other IF YES Describe: _____

Pulmonary hypertension IF YES Describe: _____

Congenital Heart Disease IF YES Describe: _____

- Atrial Septal Defect (ASD) IF YES Describe: _____
- Patent Foramen Ovale (PFO) IF YES Describe: _____
- Ventricular Septal Defect (VSD) IF YES Describe: _____
- Other Congenital Heart Disorders IF YES Describe: _____

Syncope (Fainting) IF YES Describe: _____

Any Other Cardiovascular History IF YES Describe: _____

PAST MEDICAL HISTORY- 2:

Hypertension (high blood pressure) IF YES Describe: _____
Hypotension (low blood pressure) IF YES Describe: _____

Hyperlipidemia IF YES Describe: _____
High Cholesterol IF YES Describe: _____
High Triglycerides IF YES Describe: _____

Diabetes Type 1 IF YES Describe: _____

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Diabetes Type 2 IF YES Describe: _____
Diabetic Retinopathy IF YES Describe: _____
Diabetic Neuropathy IF YES Describe: _____
Diabetic Nephropathy IF YES Describe: _____

GI Disorder

- Peptic Ulcer IF YES Describe: _____
- Reflux (GERD) IF YES Describe: _____
- Hiatal Hernia IF YES Describe: _____
- Hepatitis A IF YES Describe: _____
- Hepatitis B IF YES Describe: _____
- Hepatitis C IF YES Describe: _____
- Cirrhosis IF YES Describe: _____
- Crohn's Disease IF YES Describe: _____
- Irritable Bowel Syndrome (IBS) IF YES Describe: _____
- Ulcerative colitis IF YES Describe: _____
- Other IF YES Describe: _____

Lung disease

- Asthma IF YES Describe: _____
- COPD (Chronic obstructive pulmonary disease) IF YES Describe: _____
- Sleep apnea IF YES Describe: _____
- Pulmonary nodules IF YES Describe: _____
- Other IF YES Describe: _____

Kidney disease

- Renal Insufficiency IF YES Describe: _____
- Renal Failure IF YES Describe: _____
- Urinary Calculus (Renal Stones) IF YES Describe: _____
- Other IF YES Describe: _____

Arthritis

- Osteoarthritis IF YES Describe: _____
- Rheumatoid arthritis IF YES Describe: _____
- Scleroderma IF YES Describe: _____
- Systemic Lupus Erythematosus IF YES Describe: _____
- Psoriasis IF YES Describe: _____
- Backache IF YES Describe: _____
- Other IF YES Describe: _____

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Blood Disorders

- Anemia IF YES Describe: _____
- Thrombocytopenia IF YES Describe: _____
- Bleeding disorder IF YES Describe: _____
- Other IF YES Describe: _____

Thyroid Disease

- Hyperthyroidism IF YES Describe: _____
- Hypothyroidism IF YES Describe: _____
- Other IF YES Describe: _____

Neurology

- Stroke or cerebrovascular accident (CVA) IF YES Describe: _____
- Mini stroke or transient ischemia attack (TIA) IF YES Describe: _____
- Depression / anxiety / dementia IF YES Describe: _____
- Seizure IF YES Describe: _____
- Neuropathy IF YES Describe: _____
- Other IF YES Describe: _____

Cancer

- Breast IF YES Describe: _____
- Lung IF YES Describe: _____
- Rectal IF YES Describe: _____
- Colon Cancer IF YES Describe: _____
- Lymphoma IF YES Describe: _____
- Other IF YES Describe: _____

Edema IF YES Describe: _____

Prostate Disease (MALE ONLY) IF YES Describe: _____

Erectile Dysfunction (MALE ONLY) IF YES Describe: _____

PAST SURGICAL HISTORY-1:

Pacemaker IF YES Describe: _____
Defibrillation (ICD) IF YES Describe: _____
Bypass surgery IF YES Describe: _____
Heart valve surgery IF YES Describe: _____

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Vascular Surgery

- Leg bypass Left Right IF YES Describe: _____
- Abdominal aortic aneurysm IF YES Describe: _____
- Carotid surgery (neck) IF YES Describe: _____
- Varicose vein IF YES Describe: _____
- Other IF YES Describe: _____

PAST SURGICAL HISTORY-2:

Appendectomy (Appendix) IF YES Describe: _____
Cholecystectomy (Gallbladder) IF YES Describe: _____
Hysterectomy (Uterus) IF YES Describe: _____
Thyroid Surgery IF YES Describe: _____
Hip Surgery IF YES Describe: _____
Knee Surgery IF YES Describe: _____
Shoulder Surgery IF YES Describe: _____
Inguinal Hernia Repair IF YES Describe: _____
Prostate Surgery IF YES Describe: _____
Laminectomy IF YES Describe: _____
Cataracts IF YES Describe: _____
Limb Amputation IF YES Describe: _____
Other IF YES Describe: _____

MEDICATIONS:

Currently taking medications? **(If YES, please LIST ALL)**

1. Aspirin 81 mg / 325 mg ❒ YES ❒ NO

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

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ALLERGIES:

- Medication — IF YES Describe: _____
- Iodine / Seafood — IF YES Describe: _____
- Other — IF YES Describe: _____

SOCIAL HISTORY:

Married	❒ YES
Widowed	❒ YES
Divorced	❒ YES
Separated	❒ YES
Single	❒ YES
Significant Other	❒ YES

PROFESSION: _____

FAMILY HISTORY: (*IMMEDIATE FAMILY ONLY*)

Cardiovascular Disease - (*IF YES, CIRCLE WHO and DESCRIBE)*

- ❒ FATHER — IF YES Describe: _____
- ❒ MOTHER — IF YES Describe: _____
- ❒ SISTER — IF YES Describe: _____
- ❒ BROTHER — IF YES Describe: _____
- ❒ SON — IF YES Describe: _____
- ❒ DAUGHTER — IF YES Describe: _____

SOCIAL HABITS:

- Tobacco Use
  - Currently smoking (cigarettes) Packs per day _____ Yrs smoked _____ Yrs Quit _____

  ❒ Everyday ❒ Somedays ❒ Former smoker ❒ Never smoked ❒ Smoker-current status unknown
  ❒ Unknown if ever smoked ❒ Heavy tobacco smoker ❒ Light tobacco smoker

- Alcohol Use — ❒ YES ❒ NO — Specify: _____
- Drug Use — ❒ YES ❒ NO — Specify: _____
- Caffeine Use — ❒ YES ❒ NO — Specify: _____

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REVIEW OF SYSTEMS:

General:

- Fever IF YES Describe: _____
- Appetite change IF YES Describe: _____

Skin:

- Itching IF YES Describe: _____
- Rash IF YES Describe: _____

Eyes/Head:

- Vision IF YES Describe: _____
- Headache IF YES Describe: _____

Ears/Nose/Throat:

- Hearing loss IF YES Describe: _____
- Tinnitus (ringing in ears) IF YES Describe: _____
- Nosebleeds IF YES Describe: _____
- Sinus problems IF YES Describe: _____

Lungs:

- Wheezing IF YES Describe: _____
- Sputum (phlegm) IF YES Describe: _____

Gastrointestinal:

- Vomiting IF YES Describe: _____
- Abdominal pain IF YES Describe: _____
- Constipation IF YES Describe: _____
- Diarrhea IF YES Describe: _____

Urology:

- Urinary symptoms IF YES Describe: _____

Gynecologic:

- Vaginal discharge (FEMALE ONLY) IF YES Describe: _____

Musculoskeletal:

- Arthralgia (muscle aches) IF YES Describe: _____
- Muscle weakness IF YES Describe: _____

Neurologic:

- Weakness IF YES Describe: _____
- Speech Problem IF YES Describe: _____
- Numbness IF YES Describe: _____

Psychiatric:

- Anxiety IF YES Describe: _____
- Depression IF YES Describe: _____
- Memory problem IF YES Describe: _____

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PLEASE PROVIDE US WITH ANY COPIES OF CARDIAC PROCEDURES, TEST(s) and/or LABS to our MEDICAL STAFF for REVIEW as well as documentation for your electronic chart.

CHOLESTEROL:	**DATE**	**REPORT**
TOTAL CHOLESTEROL		
HDL CHOLESTEROL		
LDL CHOLESTEROL		
TRIGLYCERIDES		
EKG (Electrocardiogram)		
ECHO (Echocardiogram)		
TRANSESOPHAGEAL ECHOCARDIOGRAM (TEE)		
CARDIAC STRESS TEST		
HOLTER		
EVENT MONITOR		
CT ANGIOGRAM OF THE HEART (CCTA)		
TILT TABLE TEST		
VASCULAR TESTS (ULTRASOUNDS)		
CARDIAC CATH / CORONARY ANGIO		
CARDIAC STENT(s)		
PERIPHERAL ANGIO		
PERIPHERAL STENT(s)		
CAROTID ANGIOGRAM		
CAROTID STENT(s)		
RENAL ANGIOGRAM		
RENAL STENT(s)		
ABDOMINAL AORTIC ANEURYSM STENT(S)		
ELECTROPHYSIOLOGY STUDY (EPS)		
ARRHYTHMIA ABLATION		
VENOUS ABLATION		

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By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy of the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

You may decline to sign this acknowledgement.

I have ❒ received or ❒ declined a copy of the Notice of Privacy Practices.

Patient Name (print): _____

Signature of Patient or Legal Representative: _____

If Legal Representative, list Relationship to Patient: _____

Date: _____

For Office Use Only

We were unable to obtain this written acknowledgement because:

_____

_____

Initials: _____ Date: _____

Form 05/2017

Bay Area Cardiology Associates, P.A.
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize BAY AREA CARDIOLOGY ASSOCIATES, P.A. ("Provider") to disclose protected health information ("PHI") regarding:

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

I authorize the PHI be disclosed at my individual request to the following recipient:

Name: _____ Physical address: _____

Telephone number(s): _____ Fax number: _____ E-mail address: _____

Check one:

____ All health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information;

____ For a limited time period beginning _____ and ending _____ all health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes', HIV test results, genetic testing information or alcohol or drug treatment information;

____ Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed[ii]. _____

____ Other, as described here _____

I understand and acknowledge the following statements:

I. I may revoke this authorization at any time by notifying the Provider in writing of the revocation, unless the Provider has already relied on this a authorization to disclose PHI;
2. PHI disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy laws;
3. I am signing this authorization voluntarily. I may decline to sign this authorization. However. refusal to sign does not stop the Provider's disclosure of PHI that is otherwise permitted to be disclosed by law without my specific authorization;
4. Provider will not condition my treatment on whether I sign, or refuse to sign, this authorization;
5. I will receive a signed copy of this form.
6. I understand that unless otherwise revoked, this authorization will expire one year after the patient is discharged from Provider's care.

Check one:

____ I am the patient and I understand and agree to the provisions of this authorization.

____ I understand and agree to the provisions of this authorization on behalf of the patient named above. I have signed my name individually as the parent of a minor patient OR as the representative of the adult patient and have attached, or previously provided, a copy of the document authorizing me to serve as the patient's legal representative.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signature of Parent/Legal Representative/Competent Adult (if applicable) Date

_____ _____

Signature of Witness Date

' Psychotherapy notes are notes by a mental health professional documenting private counseling stored separately from the chan. To release them requires a separate release.

" The Provider is authorized by law to use or disclose PHI for a variety of reasons wlthout the patient's authorization. Please see the Provider's Notice of Privacy Practices for details.

This authorization was developed to comply with the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical health Act, the American Recovery and Reinvestment Act of 1009 and associated regulation.

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Revised as of July 31, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer for BAY AREA CARDIOLOGY ASSOCIATES, P.A. ("BACA"), Daisy Zayas at 635 Eichenfeld Drive., Brandon, FL 33511 or call: (813) 684-6000.

This Notice is provided to you in compliance with the requirements of the health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing BACA's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). BACA is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that BACA maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by BACA and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits BACA to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. BACA will comply with whichever law is stricter.

1. **Treatment:** BACA may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, BACA may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, BACA may contact you to remind you of a scheduled appointment.

2. **Payment:** BACA may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, BACA may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, BACA may disclose to a third party payer or grant funding service, and necessary, the type of services you received to reimbursement for your treatment.

3. **Health Care Operations:** BACA may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of BACA's health care professionals, business planning and development, business management and general administrative activities. For example, BACA may disclose your PHI to accreditation agencies reviewing the types of services provided.

4. **Required by Law:** BACA may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. **Public Health:** BACA may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. **Abuse, Neglect or Domestic Violence:** BACA may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and BACA believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. **Health Oversight Activities:** BACA may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

8. **Judicial and Administrative Proceedings:** BACA may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court of administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. **Law Enforcement Purposes:** BACA may disclose limited PHI about you for law enforcement purposes to a law enforcement official; (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if under limited circumstances, BACA is not able to obtain your consent; (d) if the information relates to a death BACA believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of BACA; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. **Coroners, Medical Examiners and Funeral Directors:** BACA may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining the cause of death or other duties authorized by law. BACA may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. **Research:** BACA may use or disclose your PHI for research purposes, provided than an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. **Serious Threat to Health or Safety:** BACA may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. **Specialized Government Functions:** BACA may also disclose your PHI, (a) if you are a member of the United States or foreign Armed Forces, for activities that re deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law: (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation:** BACA may disclose your PHI as authorized by, and incompliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, BACA may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care: 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) BACA has taken action in reliance on the prior authorization; or 2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure:** You have the right to request that BACA restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that BACA restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, BACA is not obligated to agree to any restriction that you request. If BACA agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use of the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). BACA will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not BACA will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Marketing and Sale of PHI:** Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization.

19. **Fundraising:** BACA may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications:** You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from BACA in alternative means or at alternative locations. BACA will accommodate all reasonable requests, but certain conditions may be imposed.

To request that BACA make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you with to receive such communications. BACA will not ask why you are making such a request.

21. **Access to PHI:** You have the right to inspect and obtain a copy of your PHI maintained by BACA. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonably anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that BACA is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, BACA may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits BACA to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is identified, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the privacy Officer. The Privacy Officer will designate a licensed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. BASCA will comply with the decision of the reviewing health care professional.

22. **Amending PHI:** You have the right to request that BACA amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. BACA may deny your request if it does not contain a reason that supports the requested amendment. Additionally, BACA may deny your request to have your PHI amended if it determined that: 1) the information was not created by BACA and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach:** BACA will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of your PHI:** You have the right to request a listing of certain disclosure of your PHI made by BACA during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you: 4) disclosures made to other people involving in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003,. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statues and regulation.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. BACA will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. BACA will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice:** You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26. If you believe that your privacy rights have been violated, you may file a complaint with BACA or with the Secretary of Health and Human Services. To file a complaint with BACA, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. BACA WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

Bay Area Cardiology Associates, P.A.
Consultative, Diagnostic & Interventional Cardiology

Dear Patient:

Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out-of-pocket maximum, and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws. **(Kickback Section 1128A of the ACT 42 U.S.C. 1320a-7a).**

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Sincerely,

Bay Area Cardiology Associates, P.A.

Bay Area Cardiology Associates, P.A.
Consultative, Diagnostic & Interventional Cardiology

FINANCIAL AGREEMENT

We, the staff of Bay Area Cardiology Associates, P.A. thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with highest level of care and to building a successful provider-patient relationship with you. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact our collection department at 813-684-9474.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, in-state checks, MasterCard, Visa and American Express). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest
Interest will incur if a balance remains unpaid after 60 days.
BALANCES OVER 60 DAYS WILL ACCRUE A 1% MONTHLY INTEREST FEE

Insurance
Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide information may necessitate patient payment for all charges. When insurance is involved we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that our-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Bay Area Cardiology Associates, P.A.
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Miscellaneous Forms, Additional Information and Authorizations
We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for disability, work or any other reason there will be an administrative fee, not to exceed $35.00 for the additional information.

Missed Appointments
We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance; a missed appointment fee will apply. These fees are typically $35.00 but not to exceed half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care of other patients.

Medical Records Fees
Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments
We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best service your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to Bay Area Cardiology Associates, PA whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charges by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: _____

Date: _____

Bay Area Cardiology Associates, P.A.
Consultative, Diagnostic & Interventional Cardiology

We understand that convenience is not often associated with today's healthcare environment. Our practice not only focuses on excellent healthcare service but also how to provide service as cost and time effectively as possible. We have found that collecting all known liability at the time of service is not only beneficial for the practice, but experience has proven that our patients appreciate knowing they will not have to worry about delayed billing or payments.

We provide secured methods of accepting your payment at the time of treatment and also for keeping your credit card on file to handle any remaining balance after insurance company reimbursement.

We will work with you in establishing a payment schedule if necessary using this credit card authorization form.

I (Guarantor Name) _____

Authorize Bay Area Cardiology Associates, P.A. to keep my signature and credit card information on file and to charge my account for balances that remain unpaid sixty (60) days following the service not to exceed $ _____ per month.

I understand the provider is offering this as a courtesy and I may pay my balance in full at any time and cancel this agreement.

I am authorizing the use of this card for: _____

Patient Name: _____

Card Holder Name: _____

Card Holder Address: _____

Type of Credit Card: _____ # _____

Expiration Date: _____ Security Code: _____

Signature: _____ Date: _____

OPTIONAL