CARDIOVASCULAR ASSOCIATES, INC.
PATIENT INFORMATION

NAME _____

LOCAL ADDRESS _____ CITY _____

STATE & ZIP CODE _____ PHONE _____

NORTHERN ADDRESS _____ CITY _____

STATE & ZIP CODE _____ PHONE _____

DATE OF BIRTH _____ AGE _____ WEIGHT _____ SOCIAL SECURITY #_____

HUSBAND/WIFE NAME _____ SOCIAL SECURITY # _____

PATIENT'S EMPLOYER _____ PHONE _____

PRIMARY INSURANCE _____ POLICY NUMBER _____

ADDRESS _____

I.D. # _____ GROUP _____ CODE _____

SECONDARY INSURANCE _____ POLICY NUMBER _____

ADDRESS _____

I.D. # _____ GROUP _____ CODE _____

PARTY RESPONSIBLE FOR THIS ACCOUNT _____

NAME OF PERSON TO CALL IN AN EMERGENCY _____

ADDRESS _____ PHONE _____
(DIFFERENT THAN YOUR HOME PHONE)

DO YOU SMOKE? YES or NO

DO YOU HAVE A LIVING WILL? YES or NO PRIMARY PHYSICIAN _____

REFERRED BY _____

EMAIL ADDRESS _____

ASSIGNMENT OF BENEFITS

For Filing Insurance

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare,Private Insurance, Major Medical Benefits and any other Health Plans to Cardiovascular Associates, Inc.Johnson P. Massey, M.D., Patrick F. Mathias, M.D., Robert L. Barrett, M.D., Thomas Y. Kim, M.D., MukeshKumar, M.D., Naushad Shaik, M.D., Jooby John, M.D., James Warren, M.D.,George Gobrial, M.D., Bethanne Smith,A.P.R.N., Brent Boro, A.P.R.N Ashley Cavallaro, A.P.R.N., Allison Germaine,A.P.R.N., Dawna Hazelwood, A.P.R.N., Petula Indar, A.P.R.N., Marilyn Velez, A.P.R.NThis assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and necessary to secure payment.

SIGNED _____ DATE _____

MEDICARE PATIENTS: Please read and sign assignment of benefits on the next page. Thank you.

PATIENT MEDICAL HISTORY

(HISTORIAL MEDICO DEL PACIENTE)

❑ Mr./Sr.
❑ Mrs./Sra.
NAME: ❑ Miss./Srta. _____
NOMBRE Last/Apellido Middle/ Segundo nombre First/Nombre de pila

❑ Single/Soltero(a)
❑ Divorced/Divorciado(a)
❑ Married/Casado(a)
❑ Widow(er)/Viudo(a)

DATE: _____
FECHA

AGE: _____ DATE OF BIRTH: _____ BIRTH PLACE: _____
EDAD FECHA DE NACIMIENTO LUGAR DE NACIMIENTO

OCCUPATION: _____
OCUPACIÓN

WHY WERE YOU REFERRED HERE:

¿CUÁL ES EL MOTIVO DE SU VISITA?

1. _____
2. _____
3. _____
4 _____

Allergies/Alergias: _____

1. _____
2. _____
3. _____

CURRENT MEDICATIONS?

MEDICAMENTOS QUE TOMA

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

RECENT, CHRONIC OR RECURRENT SYMPTOMS (circle all that apply)

SÍNTOMAS RECIENTES, CRÓNICOS O RESURRENTES (encierre en un círculo todos los que correspondan)

Chest discomfort (molestias en el pecho)
Fainting or near fainting (Desmayos o casi desmayos)
Major weight gain or loss (mayor pérdida o ganancia de peso)
Abdominal pain (Dolor abdominal)
Dizziness (Mareo)
Short of breath (Falta de aliento)
Fatigue (Fatiga)

Fever (Fiebre)
Anxiety (Ansiedad)
Depression (Depresión)
Palpitation (Palpitación)
Swelling (Hinchazón)
Cough (Tos)
Significant bleeding (from where?¬/ Sangrado significativo (de donde?_____)

PAST OR CURRENT MEDICAL PROBLEMS (circle all that apply):

PROBLEMAS MÉDICOS PASADOS O ACTUALES (marque todos los que correspondan):

Coronary Artery Disease (Arteriopatía coronaria)
Atrial Fibrillation (Fibrilación auricular)
Aortic Aneurysm (Aneurisma aortico)
Diabetes (Diabetes)
Asthma (Asma)
Liver Cirrhosis (Cirrosis hepatica)
Chronic Kidney Disease/Failure (Enfermedad / insuficiencia renal crónica)
Stroke or TIA (Accidente cerebrovascular o TIA)
Parkinson's (Enfermedad de Parkinson)
Deep Vein Thrombosis (La trombosis venosa profunda)
Myocardial Infarction ("heart attack')/ Infarto de miocardio ("ataque cardíaco")
Other Cardiac Arrhythmias (Otras arritmias cardíacas)
Peripheral Arterial Disease (Enfermedad arterial periférica
High Blood Pressure (Hipertensión)
COPD/Emphysema (COPD/Enfisema)

GERD (Enfermedad por reflujo gastroesofágico)
Arthritis (Artritis)
Seizures (Convulsiones)
HIV disease (Enfermedad del VIH)
Pulmonary Embolism (Embolia pulmonar)
Congestive Heart Failure (Insuficiencia cardíaca congestive)
Carotid Artery Disease (Enfermedad de la arteria carótida)
High Cholesterol (Colesterol alto)
Obstructive Sleep Apnea (Apnea obstructiva del sueño)
Gastrointestinal Bleeding (Hemorragia gastrointestinal)
Lupus
Dementia/Alzheimer's (Demencia / Alzheimer)
Bleeding/Clotting Disorder (Bleeding/Clotting Disorder)
Thyroid Disease (Enfermedad de tiroides)

Cardiovascular Disease of Pregnancy: Enfermedad cardiovascular del embarazo:

Pre-eclampsia/eclampsia (Pre-eclampsia/eclampsia)
Gestational Diabetes (Diabetes gestacional)
Gestational Hypertension (hipertensión gestacional)
Peripartum Cardiomyopathy (Miocardiopatía periparto)
Other (Otro)
Chemo (Quimio)
Radiation (Radiación)

CANCER (circle what type): Lung, Breast, Uterine/Cervical, Bladder, Prostate, Kidney, Colon, Liver, Pancreas, Stomach, Skin, Throat, Lymphoma, Hodgkin 's disease, Other_____

History of Chemotherapy or Radiation for Cancer? (Yes/No)

DISEASES OF PREGNANCY (circle what type): Pre-Eclampsia, Eclampsia, Gestational Diabetes, Gestational Hypertension, and Peripartum Cardiomyopathy

LIST PAST MAJOR SURGERIES (do not need to include minor outpatient procedures, and cardiac procedures/surgeries can be listed below):

1. _____
2. _____
3. _____
4. _____
5. _____

Are You a Current/Former Cigarette Smoker? (Yes/No) Former (how long ago did you quit? _____)

Current Smoker (how much do you smoke? _____) Never Smoker

How many alcoholic beverages do you drink daily? History of Alcohol Abuse (Yes/No)

FAMILY HISTORY OF HEART DISEASE? (Yes/No): If yes, who and at what age?

PAST CARDIAC TESTING AND PROCEDURES (circle below all that apply):

Open Heart Surgery (around when and where was this done?):

Pacemaker or Defibrillator (around when and where was this done?):

Ablation for Cardiac Arrhythmia (around when and where was this done?):

Coronary Angioplasty (around when and where was this done?):

Cardiac Catheterization (around when and where was the last one done?):

Stress Testing (around when and where was the last one done?):

Echocardiogram or Cardiac Ultrasound (around when and where was the last one done?):

Holter or other Heart Rhythm Monitor (around when and where was the last one done?):

Other Cardiac Procedures or Surgeries:

CÁNCER (marque el tipo con un círculo): Pulmón, Seno, Uterino / Cervical, Vejiga, Próstata, Riñón, Colon, Hígado, Páncreas, Estómago, Piel, Garganta, Linfoma, Enfermedad de Hodgkin, Otro_____

¿Historia de quimioterapia o radiación para el cáncer? (Sí No)

ENFERMEDADES DEL EMBARAZO (marque con un círculo qué tipo): preeclampsia, eclampsia, diabetes gestacional, hipertensión gestacional, miocardiopatía periparto.

HAGA UNA LISTA DE CIRUGÍAS PRINCIPALES PASADAS (no es necesario incluir procedimientos ambulatorios menores, y los procedimientos / cirugías cardíacas se pueden enumerar a continuación):

1. _____
2. _____
3. _____
4. _____
5. _____

¿Es usted un fumador de cigarrillos actual o anterior? (Sí No) Anterior (¿hace cuánto que renunció? _____)

Fumador actual (¿cuánto fuma? _____) Nunca he fumado

¿Cuántas bebidas alcohólicas bebe a diario? Historial de abuso de alcohol (Sí / No)

¿HISTORIA FAMILIAR DE ENFERMEDADES CARDÍACAS? (Sí / No): En caso afirmativo, ¿quién y a qué edad?

PROCEDIMIENTOS Y PRUEBAS CARDÍACAS PASADAS (marque con un círculo debajo todas las que correspondan):

Cirugía a corazón abierto (¿cuándo y dónde se realizó?):

Marcapasos o desfibrilador (¿cuándo y dónde se hizo esto?):

Ablación por arritmia cardíaca (¿cuándo y dónde se hizo esto?):

Angioplastia coronaria (¿cuándo y dónde se realizó?):

Cateterismo cardíaco (¿cuándo y dónde se realizó el último?):

Prueba de estrés (¿cuándo y dónde se realizó la última?):

Ecocardiograma o ultrasonido cardíaco (¿cuándo y dónde se realizó el último?):

Holter u otro monitor de ritmo cardíaco (¿cuándo y dónde se realizó el último?):

Otros procedimientos o cirugías cardíacas:

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Ashley Cavallaro, A.R.N.P

LIFETIME AUTHORIZATION FOR MEDICARE

(Patient Name) _____ (Patient's Medicare Number) _____

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to Cardiovascular Associates, Inc., for services provided by Cardiovascular Associates, Inc., Johnson P. Massey, M.D., Patrick F. Mathias, M.D., Robert L. Barrett, M.D., Thomas Y. Kim, M.D., Mukesh Kumar, M.D., Naushad Shaik, M.D., Jooby John, M.D., James Warren, M.D., Deborah Huddleston, A.R.N.P., Bethanne Smith, A.R.N.P., Paige Collins, A.R.N.P., Brent Boro A.R.N.P., Ashley Cavallaro., A.R.N.P, Katheine Vasquez-Taylor, A.R.N.P I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature _____ Date _____

I request that payment of authorized MEDIGAP benefits be made on my behalf to Cardiovascular Associates, Inc., Johnson P. Massey, M.D., Patrick F. Mathias, M.D., Robert L. Barrett, M.D., Thomas Y. Kim, M.D., Mukesh Kumar, M.D., Naushad Shaik, M.D., Jooby John, M.D., James Warren, M.D., Deborah Huddleston, A.R.N.P., Bethanne Smith, A.R.N.P., Paige Collins, A.R.N.P., Brent Boro A.R.N.P., Ashley Cavallaro., A.R.N.P. Katheine Vasquez-Taylor, A.R.N.P for any services furnished me by Cardiovascular Associates, Inc.

I authorize any holder of medical information about me to release to Cardiovascular Associates any information needed to determine these benefits or the benefits payable for related services.

Patient Signature _____ Date _____

Cardiovascular Associates

601 Oak Commons Blvd., Kissimmee, FL 34741
339 Cypress Parkway, Suite 230, Kissimmee, FL 34758
4529 Edgewater Drive, Orlando, FL 32804
3114 17th Street, St. Cloud, FL 34769
410 Celebration Place, Suite 201, Celebration, FL 34747

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information.**

_____

_____

_____

PATIENT:

X _____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature

OFFICE USE ONLY:

☐ Accepted

☐ Denied _____ _____ _____

Signature | Title | Date

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Brent Boro, A.R.N.P
Ashley Cavallaro, A.R.N.P
Allison Germaine, A.R.N.P
Dawna Hazelwood, A.R.N. P.

MISSED APPOINTMENT POLICY

Please Read CAREFULLY Before Signing:

Our office has implemented a new cancellation policy effective October 18, 2010. All appointment cancellations must be made 24 hours prior to your scheduled appointment time. Failure to cancel your appointment will generate a $25.00 Missed Appointment Fee for regular office visits, Echo, Vascular / Arterial Studies. A $150.00 Missed Testing Fee for Nuclear Stress Testing will be generated; these fees are payable before your next appointment will be scheduled.

We do realize that emergencies and illnesses arise and will consider those circumstances. To cancel your office visit appointment during normal business hours Monday through Friday from 9:00am till 5:00pm, please call (407) 846-0626, choose option 2 and then option 2 again. To cancel your Nuclear Stress Test, please call (407) 846-0626 and then put in 279, this is the direct extension to the Test Scheduler. Failure to call and cancel your appointment in a timely fashion results in an additional charge to you and your appointment slot not being made available to someone who may need to be seen.

This Missed Appointment Fee must be paid in full before we can schedule your next appointment.

Please sign the acknowledgement and acceptance of this policy in the space provided below. This notice will become part of your medical record.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature/Responsible Party Today's Date

601 Oak Commons Blvd., Kissimmee, FL 34741 • Phone: 407.846.0626 • Fax: 407.846.2524

4529 Edgewater Drive, Orlando, FL 32804 • Phone: 407.297.1870 • Fax: 407.292.7988

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Bethanne Smith, A.R.N.P.
Deborah Huddleston, A.R.N.P.
Chih Ke, A.R.N.P.
Paige Collins, A.R.N.P.

Patient Name _____

Date of birth _____

Street Address _____

City, State, Zip _____

I _____, hereby authorize Cardiovascular Associates, Inc.

And/or medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

Name _____ Relationship to the patient _____

Name _____ Relationship to the patient _____

Name _____ Relationship to the patient _____

I authorize Cardiovascular Associates, Inc. or the medical facility to contact the individual(s) listed above to convey any patient information to me, in the event I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Cardiovascular Associates, Inc. in writing of my intent to revoke authorization or change in name(s) of the individuals to whom the information is the be released.

_____ _____
Signature of Patient Date

Or, if applicable

_____ _____
Signature of Legal Guardian or Personal Representative Date

_____ _____
Name of Witness Signature of Witness

_____
Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Cardiovascular Associates, Inc.'s *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that CVA may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of CVA's *Notice of Privacy Practices* by submitting a request in writing for a current copy of CVA's *Notice of Privacy Practices*.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For CVA Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Cardiovascular Associates, Inc. made a good faith effort to obtain patient's written acknowledgment of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other _____

_____
Employee Name (printed)

_____ _____
Employee Signature Date

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Ashley Cavallaro, A.R.N.P
Katherine Vasquez Taylor, ARNP

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

COST FOR RECORDS ($1 PER PAGE I-25 PAGES, .25 EVERY PAGE THEREAFTER):_____

Patient's Name/Previous Name _____ Date of Birth/Social Security Number _____

Street Address _____ City, State, and Zip Code _____

AUTHORIZES:	TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION FROM:
Cardiovascular Associates, Inc 601 Oak Commons Blvd Kissimmee, FL 34741 Ph: (407) 846 - 0626 Fax: (407) 846 - 2371	

INFORMATION TO BE OBTAINED: I hereby authorize you to obtain/release my medical records for any treatment and laboratory/diagnostic tests performed such as:

H&P/consult/discharge	Echo/Doppler	Lab/EKG	Stress/Cath/Bypass	Xray/MRI
Records from other facilities and providers	All			

Except for:			
Sexually Transmitted Disease	H.I.V	Drug Abuse Treatment	Alcohol Abuse Treatme
Mental Health Treatment	For the following dates:		

PURPOSE FOR NEED OF DISCLOSURE:

further medical care	Insurance/Eligibility	
Other (Please specify).		

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I have the right to revoke this authorization by requesting to revoke and completing the revocation section of the form below if Cardiovascular Associates, Inc. has not acted in reliance on this authorization. I understand that Cardiovascular Associates, Inc will not be able to release my records to someone else with out a signed authorization. If I decide not to sign this form. Cardiovascular Associates, Inc. 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 and/or the organization listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization maybe re-disclosed without obtaining my authorization. I understand that I maybe charged a fee for copying these medical records.

Signature of Patient: _____ Date: _____

Signature of Patient's Legal Representative: _____

Relationship to Patient: _____

Expiration Date: This authorization is good until the following date _____ or one year from date of signature.

*** Revocation ***

(To be completed by the patient if patient subsequently wishes to revoke authorization.)

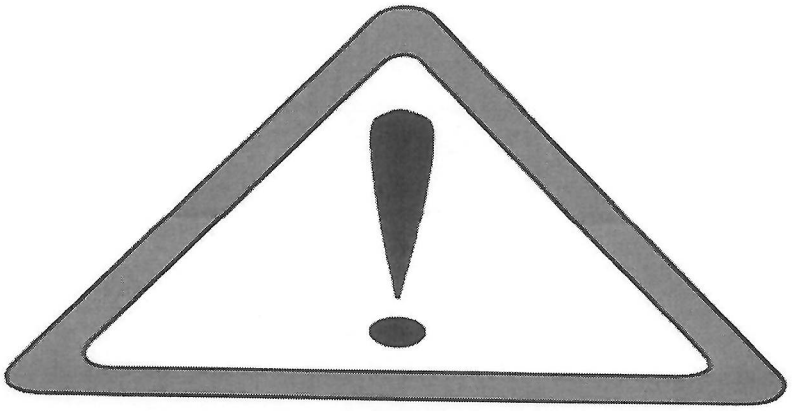
I hereby revoke this authorization. Signature: _____ Date: _____

MISSED APPOINTMENT POLICY

ALL APPOINTMENT CANCELLATION MUST BE MADE 24 HOURS PRIORS TO YOUR SCHEDULED APPOINTMENT TIME. FAILURE TO CANCEL YOUR APPOINTMENT WILL GENERATE A $25.00 MISSED APPOINTMENT FEE.

Thank You,

CVA Management



ATTENTION

CANCELLATION POLICY

FOR

TESTING PATIENTS

Appointment **cancellations** must be made **24 hours prior** to your scheduled testing time. **Failure to cancel your appointment will generate a Testing Fee,** which are payable before your next appointment can be scheduled.

NUCLEAR STRESS TEST: $150.00

ECHO/VASCULAR/ ARTERIAL *AND* TREADMILL STRESS TEST: $50.00