Saving Lives, One Heart Beat at a Time

Florida Cardiology Associates
3543 Little Road Suite- A
Trinity, Florida 34655
(727) 848-6400-Phone (727) 848-6200- Fax
Dr. Sudhir Agarwal MD, FACC, FSCAI, Dr Robert Ledbetter DO, FACC
Dr. Motaz Moussa MD, FACC, FRCPC

Thank you for choosing Florida Cardiology Associates for your cardiology needs. We Have prepared this packet of information and forms in order to make your first visit with us, a convenient and pleasant experience. We ask that you complete the attached paperwork prior to your arrival.

When you come for your appointment please bring the following:

- Completed New Patient paperwork (**do not mail in**)
- Medical Insurance Cards and Photo ID
- Bring with you any records from your previous Cardiologist
- Please let us know if you have been seen in the hospital prior to your appointment
- Bring with you an updated Medication list with current milligrams and dose information

Please be prepares to pay for the following at the time of your visit:

- Co-payment. If your insurance requires a co-pay, your are responsible for this at the time of your appointment

- If you do not have insurance, payment is expected at the time of service (unless previous arrangements have been made)

Referral/Authorizations: We will attempt to get referral/authorization from your Primary care physician; however it is always a good idea for you to call to let them Know of your appointment.

Please check in 15 minutes prior to your scheduled appointment time to allow our staff to complete the administrative portion of your appointment.

Patient Information

Date: _____ Male or Female Are you Hispanic -Y or N Race: _____
Ht: _____ Wt_____

Name: (last) _____ (first) _____ (middle) _____

Social Security Number: _____ DOB: _____ Age: _____

E-Mail address- _____ Marital Status: S M D W Sep

Address: _____ City: _____

State: _____ Zip: _____ Home phone: _____ Work phone: _____

Secondary Address: _____

_____ Backup phone number: _____

Employed by: _____ Address: _____

Notify in Case of Emergency:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Primary Physician: _____ Phone # _____

Insurance Information (Please have cards ready for receptionist)

Primary: _____ **Secondary:** _____

Policy # _____ Policy #_____

Group #_____ Group #_____

Guarantor :(name) _____ DOB: _____ SS# _____

Patient Health History

****

Patient Name: _____ SS# _____ Date: _____

Age: _____ DOB: _____ Reason for today's visit _____

Symptoms/Problems check all symptoms you currently have or have had.

General
__ Depression
__ Anxiety
__ Loss of Sleep
__ Loss of Weight
__ Nervousness
__Sweats

Neurological
__ Dizziness
__ Fainting
__ Forgetfulness
__ Headache
__ Numbness
__ Tremors

Muscle/Joint/Bone pain
__ Arms __ Legs
__ Feet __ Hands
__Neck __Shoulders
__ Back __ Hips

Respiratory
__ Shortness of Breath
__ Cough
__ Sputum __ Blood
__ Wheezing
__ Tightness
__ Pain when breathing

Cardiovascular
__ Chest pain
__ High Blood Pressure
__ Irregular heart beat
__ Low Blood Pressure
__ Poor circulation
__ Rapid heart beat
__ Swelling of ankles
__ Varicose veins

Endocrine
__ Excessive thirst
__ Too hot/cold
__ Tired/Sluggish
__other

Genitourinary
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination
__ Nighttime urination
__ Urine retention

Gastrointestinal
__ Poor Appetite
__ Bloating
__ Bowel Changes
__ Constipation
__ Diarrhea
__ Excessive hunger
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal bleeding
__ Stomach pain
__ Vomiting __ blood

Hematologic
__ Swollen glands
__ Blood clotting problems
__ Anemia

Skin
__ Bruise easily
__ Hives
__ Itching
__ Rash
__ Sore that won't heal

Eye, Ear, Nose, Throat
__ Bleeding gums
__ Blurred vision
__ Difficulty swallowing
__ Double vision
__ Hoarseness
__ Loss of hearing
__ Nosebleeds
__ Persistent cough
__ Vision-flashes

Conditions/Illness Check all conditions you currently have or have had

__ AIDS __HIV positive
__Alcoholism
__ Alzheimer's Disease
__ Anemia
__ Arthritis
__ Asthma
__ Bleeding Disorder
__ Blood Clot
__ Breast lump
__ Bronchitis
__ Cancer _____

__ Cataracts
__ Chemical dependency
__ Chronic pain _____
__Diabetes _Insulin _Pills
__ Eating disorder
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Goiter
__ Gout

__ Heart disease, if yes please explain _____
_____
__ Hepatitis __A __B __C
__ Hernia
__ High cholesterol
__ High Blood Pressure
__ Liver disease
__ Migraines
__ Miscarriage
__ Multiple Sclerosis

__ Pacemaker
__ Pneumonia
__ Prostate problems
__ Psychiatric care
__ Rheumatic fever
__ Scarlet fever
__ Thyroid problems
__ Tuberculosis
__ Ulcers
__ Other_____

Please fill out this page to its entirety

Family History Fill in health information about your family

Relation	*Age*	*State of health*	*Age of Death*	*Cause of Death*
Father	___	_____	___	_____
Mother	___	_____	___	_____
	___	_____	___	_____
	___	_____	___	_____
Sister	___	_____	___	_____
	___	_____	___	_____
	___	_____	___	_____
Brother	___	_____	___	_____
	___	_____	___	_____
	___	_____	___	_____
	___	_____	___	_____

Please circle if any blood relatives had any of the following and their relation to you

Cancer _____
Chemical dependency _____
Diabetes _____
Heart Disease; Strokes (if yes please specify) _____
_____
High Blood Pressure _____
Kidney Disease _____
Tuberculosis _____

Hospitalizations/Surgeries/Serious Illness/Injuries

Year	Hospital	Reason for Hospitalization/outcome
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____

Heart Problems

Fill in date of your last:
EKG _____
Chest X-Ray _____
Lab _____
Physical _____

Exercise

Do you exercise (please circle)

No **Minimal** **Moderate**

Health Habits Check which substance you use and answer questions

__ Caffeine __coffee __ tea __ soda How many cups/day _____
__ Tobacco __cigarettes __ cigars __ pipe How many per day_____ How long _____
__ Previous tobacco use What kind _____ When did you stop _____
__ Recreational Drugs Kind _____ How often _____ How long _____
__ Alcohol use Kind_____ How often_____ How long _____

Other

Living Will __ yes __ no
Healthcare Proxy __ yes __ no
Durable Power of Attorney __ yes __ no
Do Not Resuscitate __ yes __ no

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of FCA responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____
Print: _____
Date: _____

Name: _____

Pharmacy: _____

Name location/cross street (if any) phone number

Allergies: _____, _____, _____

_____, _____, _____

_____, _____, _____

Medicine

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

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Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Permission for Treatment

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by **FCA-Dr. Sudhir Agarwal, Dr. Robert Ledbetter, or Dr. Rami Akel** which is deemed advisable and necessary in the diagnosis/treatment of my condition. I am aware the the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past or present medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ **Date:** _____

Authorization and Assignment

I request that the payment of Authorized Medicare/Insurance Benefits be made to me or on my behalf for any services furnished by **FCA/Dr. Sudhir Agarwal, Dr. Robert Ledbetter, or Dr. Rami Akel.** I authorize any holder of medical information about me release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

Signature: _____ **Date:** _____

Designated Relative

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and healthcare operations) with:

Please list the family members or significant others, if any whom we may inform about you medical condition and/or in case of an emergency

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Messages may be left on my answering machine regarding my health and/or any appointments made _yes _no

Signature: _____ **Date:** _____

HIPAA Privacy Notice

I have received a copy of **FCA/ Dr. Sudhir Agarwal, Dr. Robert Ledbetter, or Dr. Rami Akel's** privacy notice

Signature:_____ **print name:** _____ **Date:** _____

Arterial and Venous Screening Form

Name: _____

Date: _____

**Do you experience any of the following in your legs:*

1. *Aching Pain* ☐ Y ☐ N
2. *Heaviness* ☐ Y ☐ N
3. *Fatigue / tiredness* ☐ Y ☐ N
4. *Itching / burning* ☐ Y ☐ N
5. *Swelling / cramps* ☐ Y ☐ N
6. *Restless legs* ☐ Y ☐ N
7. *Throbbing* ☐ Y ☐ N
8. *Skin or ulcer problems* ☐ Y ☐ N

**Have you had a history of:*

1. *Sclerotherapy* ☐ Y ☐ N
2. *Laser therapy (spider veins)* ☐ Y ☐ N
3. *Phlebectomy* ☐ Y ☐ N
4. *Vein Stripping surgery* ☐ Y ☐ N
5. *RF Ablation* ☐ Y ☐ N
6. *Lower Extremity Revascularization* ☐ Y ☐ N

**When you walk or exercise, do you experience pain in your arms, thighs, legs or buttocks?* ☐ Y ☐ N

**If you answered yes, does the pain subside with rest?* ☐ Y ☐ N

**Do you have painful sores or ulcers on your legs that aren't healing?* ☐ Y ☐ N

**Do you have Diabetes?* ☐ Y ☐ N

**Have you had surgery, balloon procedures or stents to any blood vessels other than your heart?* ☐ Y ☐ N

**Have you experienced temporary Loss of vision, slurred Speech, or weakness / numbness in arm or leg?* ☐ Y ☐ N

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)						
Name	Florida Cardiology Associates			Phone	727-848-6400 Fax:727-848-6200	
Address	3543 Little Rd.					
City/State Zip		Trinity		FL		34655

RECORDS FROM: (Who is **Releasing** the Records)						
Name				Phone		
Address						
City/State Zip						

For the Following Purposes:

✓	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
✓	Office Notes and Reports (Last)	✓	Diagnostic Reports		Billing Statements
✓	Rx History	✓	Transcribed Hospital Reports	✓	Laboratory Reports
✓	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record
- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other dis closures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 2.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.
We can use your health information and share it with other professionals who are treating you.
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

1) Vista
2) Quest Diagnostics

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting suspected abuse, neglect, or domestic violence

Do research
Comply with the law
Respond to organ and tissue donation requests
Work with a medical examiner or funeral director
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.