Dr Vimesh Mithani - West Florida Cardiovascular Center Inc
New Patient Forms
Please Sign and Complete the Bold Type Areas on All Pages

Date: _____ **Patient Name** _____
Date of Birth _____ **Social Security #** _____
Race: ( ) White ( ) Black ( ) Asian ( ) Italian ( ) West Indian ( ) Other _____
Ethnicity: Hispanic____ Not Hispanic_____ White _____
Home Phone _____ **Cell Phone** _____
Local Address _____
City _____ **State** _____ **Zip** _____

Mailing Address _____
City _____ **State** _____ **Zip** _____
E-Mail _____ **Employer** _____

Permanent Address _____
City _____ **State** _____ **Zip** _____

Employer Address _____
Employer Phone _____

Insurance Carrier _____ **HMO (__) YES**

Primary or Referring Doctor _____
Phone: _____ **Address** _____

Other Primary Doctor _____
Phone: _____ **Address** _____

Pharmacy I _____
Phone: _____ **Address** _____

Pharmacy II _____
Phone: _____ **Address** _____

Reason for Visit _____

In General the HIPAA Privacy Rule gives Individuals the Right to Request a Restriction on Uses and Disclosures of Health Information (PHI) The Individual is also provided the Right to Request Confidential Communications of PHI make by Alternative Means, Please Mark Your Requests Below

I Wish To Be Contacted in the Following Manner(s)

- ◯ **Home Phone**
  - ◯ Okay to Leave Message with Detailed Inform
  - ◯ Leave Message with Call Back Number Only
- ◯ **Cell Phone**
  - ◯ Okay to Leave Message with Detailed Inform
  - ◯ Leave Message with Call Back Number Only
- ◯ **Work Phone**
  - ◯ Okay to Leave Message with Detailed Inform
  - ◯ Leave Message with Call Back Number Only

Patient Signature _____ **Date** _____

Print Name _____ **Date of Birth** _____

Dr. Vimesh Mithani - West Florida Cardiovascular Center Inc.

PATIENT HISTORY AND PHYSICAL

Patient Name _____ **Date of Birth** _____

Personal History: Never Smoked __ Former Smoker ___ Current Smoker ___
Alcohol Consumption #Day___ #Week ___ Beer #Day ___ #Week ___ Caffeine ___ Cups/Day
Diet: Use Salt (__) Yes (__)No Exercise (__) Yes (__) No Routine: _____
Sleep: Hours per Night __ Difficulty Falling Asleep (__) Yes (__) No ___Snore (__)Yes (__) No

Drug Allergies - None____ Allergies to Medications _____

Family History: Check any of the conditions below which have been suffered by a Family Member and Indicate (Mother, Father, Brother, Sister).
High Blood Pressure _____ Diabetes _____ Anemia _____Arthritis _____
Heart Disease _____Asthma _____ Stroke _____ Cancer _____Heart Attack _____
Osteoporosis_____ Glaucoma _____ Depression _____ Bleeding Disorder _____
Thyroid Disease _____Emphysema _____ Mental Illness _____ Other: _____

Past Medical History:
Put check mark next to problems below you have now or have had in the past.
Anemia ____ Angina____ Anxiety ____ Asthma ____ Atrial Fibrillation ____
Bronchitis ____ Cancer ____ Chest Pain / Pressure / Tightness _____
Crohn's Disorder ____ Dyspnea/difficulty Breathing _____ Emphysema ____
Esophageal Disease ____ Fast Heart Rate ____ Gastric/Stomach Issues _____
Heart Attack ____ Heart Murmer ____ Irregular Heart Beats _____
Hepatitis/Jaundice ____ High Blood Pressure ____ Kidney Problems _____
Leg(s) Swelling ____ Low Blood Pressure ____ Migraine Headaches _____
Mitral Valve Prolapse ____ Osteoporosis ____ Palpitations ____ Stroke _____
Phlebitis ____ Prostate Problems ____ Rheumatic Fever ____ Seizures _____
Shortness of Breath ____ Skipped Heart Beats ____ Tuberculosis _____
Thyroid Disease _____ Fatigue_____ Other:_____

MEDICATIONS-STRENGHT-DOSAGE - Attach List or List Medications

_____
_____
_____
_____

HOSPITALIZATIONS: List all Cardiac Related hospitalizations, Stress Test EKG's, Holter Monitor, List Dates and Where Tests/Visits were performed.

_____
_____
_____
_____

Dr. Vimesh Mithani - West Florida Cardiovascular Center Inc

RELEASE OF CONFIDENTIAL INFORMATION

I, _____ SS# _____
(Patient Name)
Date of Birth _____ Phone # _____
Address: _____

I Authorize _____
(Name of Doctor, Facility, Hospital)

_____
Address, City, State Phone Number Fax Number

To Release Information from my Medical Records/Medical Information including

- Office Notes, Lab Work, Testing, X-rays
- Echocardiogram, Stress Test, Cath Surgery, EKG's
- Communicable Disease Testing *Other: _____

To : Dr. Vimesh Mithani - West Florida Cardiovascular Center Inc
2676 West Lake Road, Palm Harbor, FL 34684
Phone 727-786 1000 Fax : 727-786 1055

The Above Information will be Used for the Following Purpose:
Continued Medical Care _____ Insurance _____
Other _____

Patient Disclosure Statement:
I hereby authorize the use or disclosure of my individually identifiable Health Information as described above. I understand that this Authorization is Voluntary.
I Understand that if the organization Authorized to receive the Information is not a Health Plan or Health Care Provider, the Release Informior may NO Longer be Protected by Federal Privacy Regulations.

I Understand that this Consent shall be Valid for a Period of One (1) Year from the Date of Authorization and May be Revoked at any time upon Written Notice, Except to the Extent that the Information has Already Been Released in Reliance Upon the Authorization.

I Understand that I may Revoke this Authorization at any time by Notifying the Providing Organization in Writing, But if I do it will not have any affect on any actions they took prior to receiving the Revocation.

I further Understand that the confidentiality of this information may be protected by Federal Regulations, prohibiting any further disclosure of this information without specific Written Authorization of the Undersigned, or as Otherwise Regulated.

Patient's Signature _____ **Date Signed** _____
Patient Representative _____ Relation _____
Witness _____

Dr. Vimesh Mithani - West Florida Cardiovascular Center Inc

DESIGNATED RELATIVE/PERSON

I Authorize Discussion and Release of My General Medical Condition and Diagnosis, Including Treatment, Payment, and Health Care Operations, with

(___) **Spouse** (____) **Children** (____)

Other Person(s) _____

PLEASE LIST the Family Members, Significant Others, with whom We May Inform about Your Medical Condition, and in Case of Emergency

Name:_____**Relation:**_____**Phone**_____
Name:_____**Relation:**_____**Phone**_____
Name:_____**Relation:**_____**Phone**_____
Name:_____**Relation:**_____**Phone**_____
Name:_____**Relation:**_____**Phone**_____

Messages May Be Left on My Answering Machine Regarding:

My Health (__) Yes (__) No Appointments (__) Yes (__) No

Signature _____ **Date** _____

Dr. Vimesh Mithani - West Florida Cardiovascular Center Inc
HIPAA PRIVACY NOTICE

I have received a Copy of West Florida Cardiovascular Center's Privacy Notice

Signature _____ **Date** _____

Print Name _____ **Date of Birth** _____

Witness _____ Relation _____

Dr. Vimesh Mithani - West Florida Cardiovascular Center Inc

PERMISSION FOR TREATMENT

I, THE Undersigned hereby Voluntarily Consent to Medical Care/Diagnostic Treatment, and or Minor Surgical Treatment by West Florida Cardiovascular Center, Inc., deemed advisable and necessary in the diagnosis and treatment of my Condition. I am aware that 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 my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature _____ **Date** _____

Dr. Vimesh Mithani - West Florida Cardiovascular Center Inc

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by West Florida Cardiovascular Center Inc, I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents, any information needed to determine these benefits or benefits related to services.
I hereby authorize West Florida Cardiovascular Center Inc, to furnish information to CMS Insurance carriers concerning my Medical Condition, Illness and Treatment to determine the benefits for related services. I hereby authorize (Assign my Insurance Carrier(s)/CMS to make payment directly to West Florida Cardiovascular Center Inc, for Medical, Diagnostic, Surgical Benefits, for the services rendered. I understand and agree (regardless of my Insurance Status) that I am Responsible for any Charges Incurred if my account is sent to a Collection Agency and for any Returned Checks. I Understand that CMS and or other Insurance Carriers do not cover all services or procedures.
I agree to take full responsibility for any unpaid balances and that such payment will be made to West Florida Cardiovascular Center, Inc. I certify that the Information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status, my insurance or changes in the any of the above information.

Signature: _____ **Date:** _____

West Florida Cardiovascular Center, Inc.
Patient Financial Policy

Welcome to West Florida Cardiovascular Center, Inc. We are dedicated to providing you with the highest level of medical care in a compassionate and proficient manner. All patients are expected to complete a patient financial responsibility form. You will need to read carefully the Financial Policy as described below.

PATIENT FINANCIAL RESPONSIBILITY. Your co-payment will be collected on the date of service. Any deductible, co-insurance, or full-payment is due at the time the services are rendered. We cannot waive co-payments, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with various health plans. For your convenience, we accept cash, personal checks and most major credit and debit cards.

INSURANCE. Insurance information must be verified by our office prior to your visit. If you cannot provide a current medical card, full payment must be made at the time the services are rendered. It is your obligation to make certain that this office is a participating provider of your policy and that referral information and authorization has been obtained in advance of your appointment. We will file your insurance claims for you, providing that information was received by the time of your visit. It is your responsibility to notify our office of any changes in insurance coverage or personal contact information. There are timely filing restrictions for insurance claims. If we do not receive the correct insurance information within the contractual time frame, we cannot not submit the claim and the entire balance will be your responsibility.

COLLECTIONS. If we have not received payment from your insurance company within 45 days, you will be billed for the services rendered. You will also be billed for any services not covered by your insurance company. An account for which no payment is received within 60 days and for which no payment arrangements are made may be sent to collections. You will be responsible for all fees accrued, including attorney, court costs and any other fees for the expenses related to the collection of the debt. Checks returned to our office for non-sufficient funds (NSF) will incur a service charge and be processed as mandated by the State of Florida, Attorney General's office.

APPOINTMENTS. Patients are seen by appointments. If you cannot keep your appointment, it is your responsibility, as a courtesy to other patients, to call at least 24 hours in advance, so another patient has the opportunity to be seen in that time slot. We do understand that occasionally it will be necessary to change or cancel an appointment in less than 24 hours; however, if two (2) appointments are missed without notice there will be a $25 fee charged. Three missed appointments are subject to dismissal from the practice.

MEDICAL RECORDS. Should you request copies of your medical records, there is a fee charged as allowed by the state of Florida. There is also a cost associated with your request for physician "narrative reports" and /or letters not related to our insurance claims. These fees are based on the complexity and amount of time involved.

Our staff will be happy to answer any questions you may have about our policies. Thank you for allowing us to serve you.

I have read and understand the terms of this Financial Policy. I understand and agree that such terms may be amended from time to time by the Practice. I agree to assign insurance benefits to West Florida Cardiovascular Center, Inc. I authorize the release of medical information to my primary care or referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

X_____
SIGNATURE OF PATIENT

_____
DATE

WEST FLORIDA CARDIOVASCULAR CENTER
2676 WEST LAKE ROAD, PALM HARBOR, FL 34684

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____ (Print Name), have received a copy of this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____