Peace River CARDIOVASCULAR CENTER

4161 Tamiami Trail, Suite 701, Port Charlotte, FL 33952 (941)629-5356 **Fax (941)629-4987**

History and Physical

Room # _____

Please answer all info below **Date:**_____ **Chart #** _____

Name:_____**Age:** _____**DOB:** _____**Doctor:**_____

Referred by:_____**Primary Dr.** _____

Pharmacy used:_____ **Lab used:** _____

Do you have, or have you ever had any of the following? Please circle all that apply.

Weight loss	Lung disease	Nausea	Diabetes
Fever/ Chills	Asthma	Vomiting	Thyroid Disease
Night Sweats	Bronchitis	Diarrhea	Arthritis
Prior Heart attack	Pneumonia	Blood in stool	Gout
Chest pain/ Angina	Emphysema	Ulcer	Muscle Aches
Irregular heart beat	Shortness of breath	Hiatal Hernia	Blood clots
Leg cramping	Head Aches	Hepatitis	Anemia/ Bleeding
High blood pressure	Seizures	Gallstones	Cancer of _____
High cholesterol	Dizziness	UTI	Depression
Heart murmur	Fainting	Urination @ night	Anxiety
Rheumatic fever	Swelling/ Edema	Blood in urine	Heart Failure

Pacemaker/ Defib:_____ Type:_____

Drug Allergies (Please list)

***Are you allergic to IV dye, Iodine or Shellfish**

Surgeries

Date	Surgery

Current Medications

*List all meds and doses

Social History:

Occupation _____ Retired Y / N

_____ Married ____ Single ____Widowed ____ Divorced

Tobacco: Packs daily_____How long? _____ When quit?_____

Coffee: Cups daily _____ Decaf / Regular_____

Alcohol: Type & amount _____

Exercise Routine: What type & how often?_____

Family History	Father	Mother	Siblings
Age	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood pressure	_____	_____	_____
Stroke	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____

(Office use only)

HT_____**WT** _____**HR**_____**BP**_____**Reason for visit:** _____

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Our Financial Policy

In an effort to control costs and provide the best possible care for our patients, we have established the following financial policy. We hope that this will answer any questions you may have in regard to your financial responsibilities.

1. All insurance co-pays and deductibles are due at the "time of service". For your convenience, we accept Visa, MasterCard, Discover, debit card, personal checks, and cash as forms of payment at our facility. If your check is returned to us for any reason, you will be charged a $25.00 fee.

2. **If your insurance company requires a referral for you to see Dr. Hotchkiss, it is your responsibility to provide our office with a referral from your primary care physician. If your insurance company denies payment due to no referral, you the patient are responsible for any charges incurred during your visit.**

3. Keep in mind that your insurance coverage is an agreement between you and your insurance company. As a *courtesy* to our patients, we will file your initial claim for you. For Medicare patients, we will file your secondary & additional insurance as well. If payment is not received within 30 days, or a balance remains after payments are received from your insurance company, you may be billed for the balance. Insurance payments made directly to the patient for PRCVC services rendered are due to PRCVC immediately.

4. Not all insurance plans cover all services. If your insurance company determines a service is "not covered", you will be responsible for the balance. Additionally, if your insurance company only covers a percentage of the service, you are responsible for the remaining portion.

5. In the event that you have a "patient due" balance on your account at the time of a visit, you will be asked to bring your account current prior to your appointment with the Doctor. If you are unable to do this, upon completion of a financial disclosure, our Financial Department will be happy to work out a "payment plan" with you.

6. For all outstanding balances, a payment plan structure may be set up as follows:

Balance Due	**# of Months**
Less than $100	2
$100.01-$300	3
$300.01-$500	4
$500.01-$800	6
$800.01-$1500	8
$1500.01-$2500	10
$2500.01-$4000+	12

7. Any accounts with an outstanding balance after 90 days of notice, without pending insurance and/or financial arrangements, will be sent to an outside collection agency. If this is the case, you may be required to pay for any further appointments or test, in full, on the day of service.

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8. A patient under the age of 18 must be accompanied by a parent or legal guardian to authorize treatment and make financial arrangements. If a custodial parent is present but does not carry the patient on their personal insurance, we can submit charges to the patient's insurance provider. However, the parent presenting the child will be billed for any balance uncovered by the patients insurance. Patients 18 and over are financially responsible for charges incurred during each visit.

9. We require notification at least 24 hours in advance if you are unable to keep your Doctor appointment(s) to avoid a $25.00 no-show fee. No-show fee for Echo & Nuclear testing is $75.00. No-show fees will be billed to your account since insurance companies will NOT pay.

10. We will make every effort to work with you; however, reasons such as but not limited to, failure to keep appointments, non-compliance with prescribed treatment plan, abusive behavior toward staff members, and/or failure to pay your bill may result in dismissal from the practice. If dismissed from PRCVC, you are eligible for emergency treatment only. Emergency care is provided for a maximum of 30 days. After that time, you will be required to seek medical treatment from another physician/ practice.

I have read and understand Peace River Cardiovascular Center (also referred to above as PRCVC) policy and I agree to be bound by its terms. I also understand that such terms may be amended without notice by Peace River Cardiovascular Center at any time.

Signature of Patient (or responsible party, if under 18) Date

Print name of Patient Date of birth Patient account #

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below acknowledges that I have received Peace River Cardiovascular Center's Notice of Privacy Practices pamphlet and had the opportunity to ask questions regarding this notice.

X_____ _____

Patient Signature Date

Authorization to Disclose Information to a Third Person

I, _____ authorize Peace River Cardiovascular Center to release my protected health information to the person(s) listed below under the circumstances indicated. (Please initial the information you wish to be shared.)

_____ Without limitations

_____ Financial records

_____ Medical records

_____ Only if I become incapacitated

_____

Authorized Person (please print)

Relationship to patient: _____

Contact's phone#: _____

_____ Without limitations

_____ Financial records

_____ Medical records

_____ Only if I become incapacitated

_____

Authorized Person (please print)

Relationship to patient: _____

Contact's phone #: _____

X_____ _____

Authorization Patient Signature Date

OR

I choose NOT to release any of my health information to individuals (including my spouse) at this time, except as required by law, as stated in the Notice Privacy Practice.

X_____ _____

Authorization Patient Signature Date

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Medical Records Release

NAME: _____

SSN: _____

DOB: _____

I authorize Peace River Cardiovascular Center to: ☐ Obtain records from ☐ Send/ Release records to

NAME OF HOSPITAL/DOCTOR/SELF: _____

_____ CITY _____ STATE _____ ZIP CODE

_____ PHONE NUMBER _____ FAX NUMBER

☐ Continued Medical Care ☐ New Patient

MOST RECENT RECORDS NEEDED: ☐ **Office Visit** ☐ **EKG report** ☐ **Operative report**

☐ **Laboratory Results** ☐ **Stress Test** ☐ **X-Ray Report** ☐ **Echo Report** ☐ **Other:** _____

(Give 3-5 Business days for Medical Release)

I understand that my records may contain information about alcohol and/ or drug treatment, mental health or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above. I also understand that this consent will expire twelve (12) months after the date below, or when the information requested with this consent has been received/ released. A photocopy of this release shall have the same effect as the original.

_____ _____

Patient signature/ Legal Representative (relationship) Date

_____ _____

Witnessed Signature Date

Office use only: Mailed _____ Faxed _____ Pick up in person _____