Metropolitan Cardiovascular Institute

Patient Name:		**Sex:** Male ☐ Female ☐	**Date of Birth:**
Mailing Address: (Street City, State Zip)		**Home Phone:** **Cell Phone**:	**Email address:**
Name of Employer:	**Occupation:**	**Work Phone:**	**Social Security #:**
Primary Care Physician:		**Referring Doctor:**	

Responsible Party

Name of Responsible Party:	**Date of Birth:**	**Social Security #:**
Responsible Party Address:	**Phone:**	**Sex:** Male ☐ Female ☐
Relationship to patient:	**Responsible Party Employer:**	

Emergency Contact

Emergency Contact:	**Relationship to patient:**	**Phone:**

Primary Insurance Coverage

Primary Insurance Company:		**Address:**	
Subscriber Name:	**Subscriber DOB:**	**Policy #:**	**Group #:**
Is this insurance through your employer? Yes ☐ No ☐		**Patient's relationship to insured:** Self ☐ Spouse ☐ Child ☐ Other ☐	

Secondary Insurance Coverage

Secondary Insurance Company:		**Address:**	
Subscriber Name:	**Subscriber DOB:**	**Policy #:**	**Group #:**
Is this insurance through your employer? Yes ☐ No ☐		**Patient's relationship to insured:** Self ☐ Spouse ☐ Child ☐ Other ☐	

Please present all insurance cards and information to the receptionist for registration.

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PATIENT FINANCIAL RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or noncovered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Brevard Physician Associates on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Brevard Physician Associates to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Brevard Physician Associates. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Signature of Patient, Authorized Representative or Responsible Party Date Print Name of Patient, Authorized Representative or
Responsible Party Relationship to Patient

_____ _____

Signature of Patient, Authorized Representative or Responsible Party **Date**

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party **Relationship to Patient**

If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient's behalf, and provide a copy of the Durable Power document

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Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Reason for your visit: _____

Who referred you to us? _____

Primary Care Physician: _____

Any other physicians you see: _____

SURGERIES/Hospitalizations

Date	Reason	Doctor/Hospital

Have you ever smoked cigarettes? Yes ☐ No ☐ Year you started: _____ Packs/day: _____

Do you still smoke? Yes ☐ No ☐ Year you quit: _____

Do you use any other form of tobacco? Yes ☐ No ☐ Cigar Pipe Chewing Tobacco Snuff (circle)

Do you drink alcohol? Yes ☐ No ☐ How much/How often/What type: _____

Have you ever used street drugs? Yes ☐ No ☐ Past ☐ Present ☐

Does Any of your immediate family (mother, father, brother sister) have/had any of the following:

☐ Heart Disease ☐ Bypass Surgery ☐ Stroke ☐ Aneurysm ☐ Diabetes ☐ Cancer

Have you ever had a blood transfusion? Yes ☐ No ☐ If yes, did you have a reaction? Yes ☐ No ☐

Describe reaction: _____

Will you accept a blood transfusion during surgery or hospitalization if necessary? Yes ☐ No ☐

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Patient Medication List

Name: _____ Date of Birth: _____

******PLEASE LIST ALL OF YOUR MEDICATIONS – prescription, OTC, herbal supplements, vitamins, inhalers, and patches ******

Medication Name	Strength	Directions	When was it started?

Do you have any allergies? Yes ☐ No ☐

Allergy	Reaction

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Acknowledgement of Receipt of Notice of Privacy Practices

I have been made aware of Brevard Physician Associates “Notice of Privacy Practices” (“Notice”). I received a copy of this document on today’s date, and I have a right to request additional copies in the future. The Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Brevard Physician Associates healthcare operations. The Notice also describes my rights and Brevard Physician Associates responsibilities with respect to my protected health information.

I understand that copies of the Notice are available in the registration areas of each facility and on Brevard Physician Associates system website at www.vascularbrevard.com I understand that I may request a copy of the Notice at any time. Brevard Physician Associates reserves the right to change the privacy practices that are described in the Notice at any time and will make a revised Notice available for review. I may obtain a revised Notice of Privacy Practices by requesting a copy or by accessing Brevard Physician Associates website listed above.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient (if not signed by the patient)

_____ _____

Witness Signature Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(ALL SECTION MUST BE COMPLETED)

Name: _____ Date of Birth: _____

I hereby authorize Brevard Physician Associates to release or disclose to the below named recipient(s) all of my medical records including any specially protected records, such as those related to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection (unless otherwise indicated.

I hereby authorize the release of my records to:

Name: _____ Address: _____

The authorization will expire on: _____ (date or event may not exceed one year)
Purpose of release (i.e. evaluate for surgery, evaluate condition, second opinion, attorney, etc.)

This authorization applies to (initial all applicable)

_____ All medical records

_____ Healthcare information relating to the following treatment, condition, or dates of treatment: _____

_____ Specific records to be released (i.e. labs, imaging, reports, other):

_____

I am aware that I have the right to inspect and receive a copy of the information I have authorized to be used and/or disclosed by this Authorization. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I am aware that I may revoke this Authorization at any time in writing; however, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; (2) as authorized by law. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information.
By my signature, I knowingly and voluntarily authorize the transfer of my health information in the manner described above.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient (if not signed by the patient)

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General Consent for Evaluation and Treatment for Patients

TO THE PATIENT:

Welcome to Metropolitan Cardiovascular Institute. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs.

This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care.

You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used.

You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits

The consent will remain fully effective until it is revoked in writing.

You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative Relationship