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 herby 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., 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., Chih Ke, A.R.N.P. This 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 MÉDICO DEL PACIENTE

NAME: ❑ Mr./*Sr.* ❑ Mrs./*Sra.* ❑ Miss./*Srta.* ______________________
NOMBRE Last/*Apellido* Middle/*Inicial* First/*Nombre de pila*

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

DATE: ____________
FECHA

AGE: ____________ *EDAD*
DATE OF BIRTH: ____________ *FECHA DE NACIMIENTO*
BIRTH PLACE: ____________ *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

____
____
____
____
____
____
____
____

CURRENT SYMPTOMS/*SÍNTOMAS*:

❑ Weight Loss
Pérdida de peso
❑ Weight Gain
Subida de peso
❑ Fever or Chills
Fiebre o escalofríos
❑ Difficulty in Exercising
Dificultad para hacer ejercicio
❑ Change in Hair
Cambios en el pelo
❑ Change in Nails
Cambios en la uñas
❑ Rashes
Sarpullidos
❑ Skin Lesions
Lesiones en la piel
❑ Double Vision
Doble visión
❑ Glaucoma
Glaucoma
❑ Field of Vision Problems
Problemas con el campo de visión
❑ Hearing Loss
Problemas de oído
❑ Nose Bleeds
Hemorragias nasales
❑ Hoarseness
Ronquera
❑ Difficulty Speaking
Dificultades al hablar
❑ Shortness of Breath
Dificultades al respirar
❑ Cough
Tos
❑ Wheezing
Silbidos al respirar
❑ Coughing up Blood
Tos con sangre

❑ Stomach Ulcers
Úlceras estomacales
❑ Blood in Stools
Sangre en las deposiciones (heces)
❑ Black Tarry Stools
Deposiciones alquitranadas
❑ Varicose Veins
Varices
❑ Swelling in the Legs
Hinchazón en las piernas
❑ Arthritis
Artritis
❑ Back Pain/Problems
Dolores de espalda
❑ History of Depression
Historial de depresión
❑ Substance Abuse
Problemas de alcohol o drogas
❑ Difficulty in Thinking
Dificultades para pensar
❑ None of the Above
Ninguno de los anteriores

FAMILY HISTORY
HISTORIAL FAMILIAR

Has Any Blood Relative Ever Had: *Ha tenido alguno de sus parientes consanguíneos:*	No *No*	Yes *Sí*	Who *Quién*	Age on Onset *Edad al descubrirse*
Heart Trouble / *Problemas cardíacos*				
High Blood Pressure *Tensión sanguínea alta*				
Cancer / *Cáncer*				
Diabetes / *Diabetes*				
Stroke / *Derrame cerebral*				
Other / *Otra*:				

PAST CARDIAC ILLNESSES:
ENFERMEDADES CARDÍACAS PREVIAS

❑ Angina
Angina de pecho
❑ Cardiac Arrhythmias
Arritmia cardíaca
❑ Atrial Fibrillation
Fibrilación auricular
❑ Cardiomyopathy
Miocardiopatía
❑ Congestive Heart Failure
Insuficiencia cardíaca congestiva
❑ Coronary Artery Disease
Cardiopatía isquémica
❑ Valvular Heart Disease
Valvulopatía
❑ Prior Heart Attack
Ataque previo al corazón
❑ Prior Angioplasty or Stent
Endoprótesis vascular o angioplastia previa
❑ Prior Coronary Artery Bypass Surgery
Injerto de revascularización coronaria previo
❑ Prior Valvular Heart Surgery
Cirugía previa de valvulopatía
❑ Prior Pacemaker/Defibrillator
Marcapasos o desfibrilador previo

❑ Other / *Otra*: ____________
____
____

PAST SURGICAL PROCEDURES:
OPERACIONES QUIRÚRGICAS PREVIAS:

- ❑ Abdominal Aortic Aneurysm Surgery
  Cirugía de aneurisma aórtico abdominal
- ❑ Amputation
  Amputación
- ❑ Knee Surgery
  Cirugía de rodilla
- ❑ Back Surgery
  Cirugía de espalda
- ❑ Bladder Suspension/Surgery
  Suspensión/cirugía uretropélvica
- ❑ Breast Surgery (Please circle):
  Cirugía de mama (rodear con un círculo):
  Augmentation, Biopsy, Mastectomy
  aumento, biopsia, mastectomía
- ❑ Carotid Surgery
  Cirugía de la carótida
- ❑ Cataract Surgery
  Cirugía de cataratas
- ❑ Carpal Tunnel Surgery
  Cirugía del túnel carpiano
- ❑ Cesarean Section
  Cesárea
- ❑ Gallbladder Surgery
  Cirugía de la vesícula
- ❑ Colostomy
  Colostomía
- ❑ Colon Surgery
  Cirugía de colon
- ❑ Eye Surgery
  Cirugía del ojo
- ❑ Elbow Surgery
  Cirugía de codo
- ❑ Vascular Bypass Surgery of the Legs
  Revascularización quirúrgica de las piernas
- ❑ Gastrectomy
  Gastrectomía
- ❑ Gastric Stapling
  Grapado gástrico
- ❑ Hemorrhoid Surgery
  Cirugía de hemorroides
- ❑ Hysterectomy
  Histerectomía
- ❑ Hernia Repair
  Reparación de hernia
- ❑ Hip Replacement
  Reemplazo de cadera
- ❑ Laminectomy
  Laminectomía
- ❑ Lung Surgery
  Cirugía del pulmón
- ❑ Prostate Surgery
  Cirugía de la próstata
- ❑ Shoulder Surgery
  Cirugía de hombro
- ❑ Thyroid Surgery
  Cirugía de la glándula tiroidea
- ❑ Tonsillectomy
  Amigadalectomía
- ❑ Tubal Ligation
  Ligadura de trompas
- ❑ Ulcer Repair
  Reparación de úlceras
- ❑ Vasectomy
  Vasectomía
- ❑ Vein Stripping
  Extirpación venosa

PAST MEDICAL HISTORY
HISTORIAL MÉDICO PREVIO

HAVE YOU EVER HAD:
HA SUFRIDO ALGUNA VEZ

- ❑ Abdominal Aortic Aneurysm
  Aneurisma aórtico abdominal
- ❑ Anemia
  Anemia
- ❑ Anxiety
  Ansiedad
- ❑ Asthma
  Asma
- ❑ Arthritis
  Artritis
- ❑ Bi-Polar Disease
  Trastorno bipolar
- ❑ Blindness
  Ceguera
- ❑ Prostate Enlargement
  Hipertrofía prostática
- ❑ Bronchitis
  Bronquitis
- ❑ Cataract
  Cataratas
- ❑ Carotid Artery Disease
  Arteriopatía carotídea
- ❑ Ulcerative Colitis
  Colitis ulcerosa
- ❑ Chronic Emphysema (COPD)
  Enfisema crónico (COPD)
- ❑ Stroke/Mini-Stroke
  Derrame / miniderrame cerebral
- ❑ Cancer (Circle what type):
  Cáncer (rodear con un círculo):
  Breast, Cervical, Bladder, Colon,
  mama, cuello uterino, vejiga, colon,
  Kidney, Liver, Lung, Pancreas,
  riñón, hígado, pulmón, páncreas,
  Prostate, Stomach, Uterus,
  próstata, estómago, útero,
  Skin, Throat
  piel, garganta
- ❑ Gallbladder Disease/Gallstones
  Colescitopatía / cálculo vesical
- ❑ Liver Cirrhosis
  Cirrosis del hígado
- ❑ Alzheimer's Disease
  Enfermedad de Alzheimer
- ❑ Depression
  Depresión
- ❑ Diabetes
  Diabetes
- ❑ Diverticulitis/Diverticulosis
  Diverticulitis / diverticulosis
- ❑ Peptic Ulcer Disease
  Úlcera péptica
- ❑ Phlebitis
  Flebitis
- ❑ Endometriosis
  Endometriosis

- ☐ Erectile Dysfunction/Impotence
  Disfunción eréctil / impotencia
- ☐ Esophagitis/Gastritis
  Esofaguitis / gastritis
- ☐ Fibromyalgia
  Fibromialgia
- ☐ Glaucoma
  Glaucoma
- ☐ GERD or Hiatal Hernia
  GERD o hernia de hiato
- ☐ Gout
  Gota
- ☐ Headaches/Migraines
  Dolores de cabeza / jaqueca
- ☐ Hemorrhoids
  Hemorroides
- ☐ Hernias
  Hernias
- ☐ HIV Disease
  VIH
- ☐ Hodgkins' Disease
  Enfermedad de Hodgkins
- ☐ Hyperlipidemia or High Cholesterol
  Hiperlipidemia o colesterol alto
- ☐ High Blood Pressure or Hypertension
  Tensión sanguínea alta o hipertensión
- ☐ Thyroid Disease
  Disfunción tiroidea
- ☐ Irritable Bowel Syndrome
  Síndrome del colon irritable
- ☐ Kidney Stones
  Piedras de riñón
- ☐ Leukemia
  Leucemia
- ☐ Lupus
  Lupus
- ☐ Lymphoma
  Linfoma
- ☐ Macular Degeneration
  Degeneración macular
- ☐ Obesity
  Obesidad
- ☐ Osteoporosis
  Osteoporosis
- ☐ Pancreatitis
  Pancreatitis
- ☐ Panic Attacks
  Ataques de pánico
- ☐ Parkinson's Disease
  Enfermedad de Parkinson
- ☐ Pneumonia
  Neumonía
- ☐ Prostatitis
  Prostatitis
- ☐ Poor Circulation (Peripheral Vascular Disease)
  Mala circulación (vasculopatía periférica)
- ☐ Rheumatic Fever
  Fiebre reumática
- ☐ Renal or Kidney Failure
  Insuficiencia renal (riñón)
- ☐ Scoliosis
  Escoliosis
- ☐ Seizures
  Convulsiones
- ☐ Sleep Apnea
  Apnea del sueño
- ☐ Varicose Veins
  Varices
- ☐ Vertigo
  Vértigo

Do You Smoke?
¿Fuma?

Year Quit ____________________
En qué año lo dejó

Packs per day____________
Paquetes al día

Number of Years__________
Cuántos años

Alcoholic Beverages:
Bebidas alcohólicas:

☐ Never *Nunca* ☐ Rarely *Casí nunca*
☐ Moderate *Moderadamente* ☐ Heavily *Mucho*

☐ Beer
Cerveza

☐ Wine
Vino

Number of Years ______________
Cuántos años

☐ Other
Otras:

What Do You Consider Yourself?
Indique cuánto bebe

☐ Non Drinker *No bebo* ☐ Social Drinker *Bebo en situaciones sociales*
☐ Moderate Drinker *Bebo moderadamente* ☐ Heavy Drinker *Bebo mucho*
☐ Alcoholic *Alcohólico* ☐ Formerly an Alcoholic *Ex-alcohólico*

NAMES OF PHYSICIANS THAT ARE FAMILIAR WITH YOUR MEDICAL CONDITION:
NOMBRE DE LOS MÉDICOS QUE CONOCEN EL TRASTORNO MÉDICO QUE SUFRE

____
____
____
____
____

CARDIOVASCULAR ASSOCIATES, INC.
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Deborah Huddleston, A.R.N.P.
Bethanne Smith, 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. and Chih Ke, 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. and Chih Ke, 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 ______________________

601 Oak Commons Blvd., Kissimmee, FL 34741
339 Cypress Parkway, Suite 230, Kissimmee, FL 34758
4529 Edgewater Drive, Orlando, FL 32804
2900 17th Street, Suite 5, St. Cloud, FL 34769
42719 Hwy. 27, Suite 103, Davenport, FL 33837
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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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. After hour calls placed to (407) 846-0626 will be handled by our Answering Service. 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.

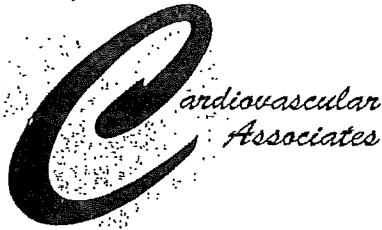
______________________________ ______________

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

Patient Name: ______________________________

Date of Birth: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

I ______________________, hereby authorize Cardiovascular Associates Inc.
Name of patient

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 patient: __________

Name: ________________ Relationship to patient: __________

Name: ________________ Relationship to 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.

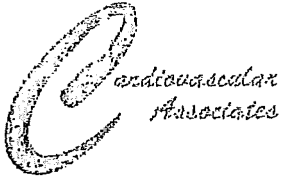
I understand that I may revoke/cancel this authorization by notifying Cardiovascular Associates Inc. in writing of my intent to revoke authorization or change in name(s) of the individuals to whom the information is to be released.

______________________ ______________________
Signature of Patient Date

Or if applicable

______________________ ______________________
Signature of Legal Guardian or Personal Representative Date

______________________ ______________________ ______________
Name of Witness Witness Signature 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

Cardiovascular Associates Patient Agreement

Welcome to Cardiovascular Associates. Our goal is to provide you with the best Cardiovascular care, and doing that requires that we work together to accomplish that goal.

Our Staff & Services

We employ masters prepared **Nurse Practitioners** who work under your physicians' direction to closely follow your care, especially when there is a need for more frequent visits to manage a number of chronic illnesses, for example, congestive heart failure, or hypertension. We also have **RN's** who assist us in the hospital and office to help direct and follow your care.

Our **Medical Assistants (MA)** will be preparing you for your visit with your provider. They ask questions that your physician has directed them to ask, and may perform an electrocardiogram (ECG) or other testing deemed necessary by your physician. It is extremely important that you bring either a list of your current medications or the medication bottles with you for each visit so we have an accurate record of what you are taking. Many medications prescribed by other physicians may affect your heart or the effectiveness of your cardiac medications. If you require an interpreter, please bring a family member or friend with you.

____**Prescription Refills:** Please do not wait until the last minute to request refills. It might be helpful to put the refill dates on your calendars at least 1 week before you need them. Our **MA's** refill your prescriptions from voice mail on our prescription line, ext. 236, throughout the day. Most are completed the same day. On high volume days it may take 24 hours. We do not accept walk-in refill or sample medicine requests. Because we use an electronic medical record, your prescriptions are sent to your Pharmacy's computers, NOT a fax machine. If they can't find them, you may have to remind them to check their computers, as many offices in the area do not have electronic records.

____**Sample Medications:** Your physician may offer you sample medications to make sure they are effective before you fill a prescription, or to allow you to start them right away while you are waiting for the pharmacy to fill our prescription. **Sample medications are a courtesy and not to be depended on for continued treatment.**

Our **appointment and procedure schedulers** provide your appointment times, and reminder calls then forward information as needed to our Medical Records and Authorizations staff to make sure any records or referrals needed are requested in a timely manner. Please remember that our staffs' ability to acquire your information for your visit is dependent upon the responsiveness of your primary care physicians' office.

- Please arrive 15 minutes before your scheduled appointment
- Have your insurance card (s) and any updated address or phone information ready for the check-in staff
- If you are late more than 20 minutes past your appointment time, your appoint will be cancelled

____Our **front office staff** is responsible for welcoming you to our office and reviewing or collecting all the information required to make sure your personal information is up-to- date, and your insurance information is accurate. This **must** be done at every visit without exception. Please remember, we are required by law to abide by the contractual requirements of the insurance company that **you** have chosen. Co-pays are dictated by your insurance contract and we are required to collect co-pays at the time of your visit.

Echocardiography & Vascular Labs

These procedures are non-invasive and utilize sound waves to create images of your heart, heart valves, or blood vessels. It provides your physician with invaluable information about the structures and function of your heart and peripheral vessels. Our sonographer is certified by the ARDMS in echocardiography and vascular technology, and has over 25 years of experience.

Nuclear Cardiology & Stress Testing

Our Nuclear lab is accredited by the Intersocietal Commission for the Accreditation of Nuclear Labs (ICANL). Stress testing provides your physician with information about how your heart and blood pressure respond to exercise. The nuclear imaging portion provides images of the perfusion of blood flow in the heart muscle. Both are non-invasive tests which help your physician diagnose many cardiac conditions, for example, blockages in the coronary arteries or arrhythmias, and evaluate effectiveness of cardiac medications.

Device Clinic

Our device clinic evaluates the functioning of your Pacemaker, or Automated Internal Cardiac Defibrillator (AICD) in the office, and in many cases, from your home via tele-monitoring. Our staff works very closely with the industry clinical specialists and our Electrophysiologist to provide you individualized care for your specific device.

Laboratory

____For your convenience, we offer an on-site lab for your blood work. We may monitor your PT/INR's, cholesterol, or other cardiac blood work. You may have insurance that requires you to have your lab work done at a lab other than ours. If you've had blood work at another lab since your last visit, please bring it with you.

Our employees are an important asset and we make every effort to hire and train staff that will provide you with compassionate care in a respectful manner. Likewise, we expect that you communicate with our staff in that same respectful manner. Thank you for allowing us to be part of your cardiovascular health.

Cardiovascular Associates

Patient Signature: ______________________________ Date: ______________________

CARDIOVASCULAR ASSOCIATES, INC.

Johnson P. Massey, M.D., F.A.C.C.
Patrick F. Mathias, M.D., F.A.C.C., F.C.C.P., F.A.C.P.
Robert L. Barrett, M.D. F.A.C.C.
Thomas Y. Kim, M.D., F.A.C.C.
Mukesh Kumar, M.D., F.A.C.C., F.S.C.A.I.
Naushad Shaik, M.D., F.A.C.C.
Jooby John, M.D., F.A.C.C.
James Warren, M.D., F.A.C.C.
Deborah Huddleston, A.R.N.P.
Bethanne Smith, A.R.N.P.
Chih Ke, A.R.N.P.

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

COST FOR RECORDS ($1 PER PAGE 1st 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:

The most recent of the following:				
H&P/consult/discharge	Echo/Doppler	Lab/EKG	Stent/Cath/Bypass	Xray/MRI
Records from other facilities and providers	Last Office Note	Holter	Stress	Sleep Study

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: ______________________________

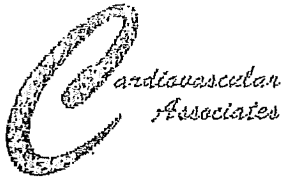
Relationship to Patient: ______________________________

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: __________



Cardiovascular Associates, Inc.

Please fill the information below so that we may provide you the best of care.

Name: ______________________ **D.O.B.** ____________ **Date:** ____________

Alcohol use: ___ Never ___ Rarely ___ Moderate ___ Heavy

Smoking tobacco use: ___ Non-smoker ___ Former smoker ___ Current some days smoker **Start date:** ____________

___ Light Tobacco smoker ___ Heavy tobacco smoker **Quit Date:** ____________

Diet: ___ Well ___ Somewhat healthy ___ Not good

Caffeine use: ___ Yes ___ No ___ Coffee ___ Tea ___ Soda

Exercise: ___ Yes ___ Sometimes ___ Never

Substance Abuse: ___ Yes ___ No If so, what? ____________

Life Style: ___ Married ___ Single ___ Divorced

___ Widowed ___ Partner

Education: ___ High School ___ Some College ___ College

Occupation: ____________ **Job Description:** ____________

Hours worked weekly: ____________

Spouse/ Partner occupation: ____________

Sexual Activity: ___ Yes ___ No

Residence: ____________

Seat belt use: ___ Yes ___ Sometimes ___ Never

Place of birth: ____________

Pharmacy: Name: ____________

Address: ____________

Zip code: ____________ Phone: ____________