Nipun Arora, M.D. FACC
Vikas Verma, M.D. FACC

ORLANDO CARDIAC & VASCULAR SPECIALISTS LLC

Rajesh Shah, M. D. FACC
Sambit Mondal, M.D. FACC

PATIENT REGISTRATION

Directions: Please complete all sections, initial where necessary, and sign at the bottom. Write/check N/A if not applicable.

Patients' Demographics

Last Name:	First Name:	MI:	Date:
Sex: ☐ M ☐ F	DOB: ___/___/_____ Age:	SSN:	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed
Home Phone#:	Cell / Alternative Phone #:		Email:
How do you prefer to be contacted? ☐ Home Phone ☐ Cell/Alternative Phone ☐ Email			
Address:	City:	State:	Zip:
Status: ☐ Employed ☐ Student ☐ Disabled ☐ Unemployed ☐ Retired	Employer Name: N/A ☐	Work Phone:	

Patients' Care

How did you hear about us? ☐ Family ☐ Friend ☐ Employer ☐ Doctor ☐ Other _____		
Primary Care Doctor Name:	Phone Number:	Fax Number:
Referring Doctor Name:	Phone Number:	Fax Number:
PHARMACY Name:	Location:	Phone Number:

Insurance Information

Do you have Health Insurance: ☐ Yes (A copy will be placed in chart) ☐ No/Self Pay **(You will be asked for insurance at every visit)**		
Primary Insurance Name:	Group Number:	ID/Policy Number:
Primary Insurance Phone Number:	Relationship to Policy Holder/Name: ☐ Self	
Secondary Insurance Name:	Group Number:	ID/Policy Number:
Secondary Insurance Phone Number:	Relationship to Policy Holder/Name: ☐ Self	

~~***EMERGENCY CONTACT INFORMATION***~~

1.Name:		2.Name:	
Relationship:	Phone:	Relationship:	Phone:
OCVS has permission to discuss my medical care with myself and the following: ☐ ***1. Name:*** ☐ ***2. Name:*** ☐ ***Other:***_____			

CONSENT TO FOR TREATMENT & INSURANCE ASSIGNMENT AGREEMENT

I authorize Orlando Cardiac & Vascular Specialists LLC (OCVS) to ***examine me and order/perform such tests, procedures and/or treatment that are reasonable and necessary in the diagnosis and treatment of my case***. I hereby acknowledge that I am seeking medical care on my volition without any coercion.

I furthermore authorize payment from any insurance company or any governmental agency to OCVS for any medical or surgical benefits otherwise payable to me for the services provided by OCVS, but not to exceed the reasonable and customary charge for these services. ***I understand that I am financially responsible for charges not paid by this assignment. I further understand that it is my responsibility to understand the coverage my insurance policy provides including any out of pocket expenses I am responsible for as well as the referral and authorization process for services.***

Signature of Patient or Patient Representative:_____ Date: _____

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MEDICAL HISTORY, MEDICATIONS AND ALLERGIES

Medical History

☐ No Known Medical History

Please check the following if you are known to have these:

☐ Pacemaker: *(Specify Brand)* _____ Are we following care? ☐ Yes ☐ No

- ☐ Angina (Chest Pain)
- ☐ Palpitations
- ☐ Atrial Fibrillation/Flutter
- ☐ Cardiomyopathy
- ☐ Carotid Stenosis
- ☐ Coronary Artery Disease (CAD)
- ☐ Congestive Heart Failure
- ☐ CVA (Stroke)
- ☐ Hypertension (High Blood Pressure)
- ☐ Ischemia
- ☐ Mitral Valve Regurgitation (MVR)
- ☐ Postural orthostatic tachycardia syndrome (POTS)
- ☐ Tachycardia or Bradycardia
- ☐ Chronic Vein Insufficiency
- ☐ Deep Vein Thrombosis
- ☐ Pedal Edema (Swelling of feet)
- ☐ Peripheral Arterial/Vein Disease
- ☐ Renal Disease
- ☐ Varicose Veins
- ☐ Dizziness
- ☐ Fatigue
- ☐ Syncope/Vasovagal (Fainting)
- ☐ Dyspnea (Shortness of Breath)
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Anemia
- ☐ Alzheimer's/Dementia
- ☐ Neurological Disease
- ☐ Sleep Apnea
- ☐ Cancer
- ☐ Thyroid disease (Hyper/Hypo)
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Seizures and epilepsy
- ☐ Diabetes Type 1 or 2
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Other: _____

Medications

☐ No Medications Taken

Please list all current medications including Prescription, Non Prescription (ex. Aspirin), and Supplements you are taking: ☐ See Attached Med List:

Medication Name	Dosage	Frequency

Allergies

☐ No Known Allergies

Please list all known allergies: _____

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Dear Patient,

Thank you for choosing Orlando Cardiac & Vascular Specialists LLC for your specialty healthcare needs. We are pleased to welcome you to our practice. We'd like to familiarize you with our office policies to keep you informed and avoid any potential misunderstandings.

APPOINTMENTS: In the event that you cannot keep a scheduled appointment, please provide a minimum of 24 hours' notice to avoid a **no show/cancellation fee of $25.00** being charged to your account. Diagnostic Testing Services and Procedures require a minimum of 48 hours' notice or a higher no show fee may be charged. This allows us to schedule other patients in the vacant appointment slot and decrease appointment wait times.

REFERRALS: If your insurance policy requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain such referral prior to your scheduled appointment. If you do not have a valid referral, your appointment will be rescheduled.

CO-PAYMENTS AND DEDUCTIBLES: By law, we are required to collect your carrier designated copayment (co-pay). This payment is due at the time of service. Any diagnostic testing or procedures performed may require a separate co-pay, deductible, and/or coinsurance. We will collect such balance at the time of service.

SELF PAY PATIENTS: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Self Pay: ● New Patient 1st Visit ONLY:$170 ● Follow Up Visit ONLY:$100

FMLA/DISABILITY FORM COMPLETION: Please have FMLA and/or disability paperwork completed by your PCP wherever possible. In the event, that you may need FMLA and/or disability paperwork completed by our office, a $30.00 charge will apply. Please allow a minimum of 10 business days for the completion of these forms.

MEDICAL RECORDS REQUESTS: We will provide you with a copy of your medical records upon request.
******A charge of $1.00 per page will be assessed for the first 25 pages and $0.25 per page thereafter******
This fee covers the cost of reproducing these records. There will be no charge if records are sent to another physician. OCVS is only permitted to release our office records only.

REFILL REQUESTS: Medication refills will be sent electronically to your pharmacy. Please provide us with your pharmacy name, address, and phone number and notify us of any changes as soon as possible. Refills are generally processed at your scheduled appointment: however, please call our office during business hours if refills are needed prior to your scheduled appointment date. *Please allow a minimum of 72 business hours for processing these requests.*

ACCEPTED PAYMENT TYPES:Cash, check or card (Visa, MasterCard, American Express, and Discover) are acceptable forms of payments. A $25.00 fee will be charged to the patient's account for checks returned due to insufficient funds.

By initialing here, I am agreeing that I have read the information above. → _____

MEDICARE PATIENTS ONLY

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize OCVS to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or related Medical claims. I hereby authorize payment directly to OCVS for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to, routing testing may not be covered by Medicare unless the physician provides medical necessity.

☐ Not Applicable

_____
Initial

PATIENT NOTIFICATION RESPONSIBILITY

If my follow-up appointment for any study, test and/or procedure is cancelled or rescheduled by myself or by OCVS, I understand it is my responsibility to contact the office within 7—10 days after the study/test/procedure has been completed to verify results are negative/normal/stable and no other testing/office visit is necessary.

_____
Initial

ORIGINAL ASSIGNMENTS. AUTHORIZATIONS. AND RELEASES ON FILE

I permit a copy of the above assignments, authorizations, and releases to be used in place of the original, which has been filed in the office of Orlando Cardiac & Vascular Specialists LLC.

_____
Initial

PATIENT/GUARANTOR

If proper authorization is not obtained from my Primary Care Physician (PCP), I will be liable for charges incurred for those services. I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance may be due from me.

_____
Initial

ADVANCED DIRECTIVES: (For compliance with the patient self-determination act)

Have you executed an advanced directive? ☐ YES ☐ NO
(Have you decided upon the degree of care you want in the event of a catastrophic medical event?)

- If **YES**, is this directive in the form of: ☐ A LIVING WILL ☐ A DURABLE POWER OF ATTORNEY ☐ HEALTH CARE SURROGATE
- If you have executed an advanced directive in any of the above formats, have you provided this office with a copy for your medical records? ☐ YES ☐ NO

PATIENT CONSENT / NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA) of 1996, I have certain privacy rights related to my protected health information (PHI). I understand this information can be used to:

1) Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in such treatment directly and indirectly.
2) Obtain payment from third party payers.
3) To conduct normal healthcare operations such as quality assurance and physician certifications.

I have been informed of Orlando Cardiac & Vascular Specialists LLC's Notice of Privacy Practices which provides a more complete description of how my PHI may be used or disclosed. I understand that I have the right to review this Notice before signing this form. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of the Notice.

- ✓ I understand that while this consent is voluntary, Orlando Cardiac & Vascular Specialists can refuse to treat me should I refuse to sign it. I further understand that I have the right to request how my PHI is used or disclosed to carry out treatment, payment or health care operations. I also understand that the organization is not required to agree to my restrictions, but if they do agree, then they are bound to abide by such restrictions.
- ✓ I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already made releases relying on my prior consent.

Attestation: By signing this form, I consent to the Orlando Cardiac & Vascular Specialists LLC's use and disclosure of my protected health information to carry out treatment and health care operations and/or determine a claim for payment as described in their Notice. By signing below, I also agree to all information stated herein and understand my rights and responsibilities as a patient of the Orlando Cardiac & Vascular Specialists LLC .

_____ _____
Printed Name of Patient or Patient Representative Date

☐ Self

_____ _____
Signature of Patient or Patient Representative Relationship to Patient