WELCOME TO OUR PRACTICE
1111 S. Semoran Blvd. Ste A. Orlando, FL 34741
812 W Oak Street, Kissimmee, FL 34741
email: cardio@gio.care | (407) 480-4445 | Fax: (407) 480-4446

PERSONAL INFORMATION *(Informacion Personal)*

Name: ____Date of Birth: ____/____/____ Age:_________
Nombre *Fecha de Nacimiento* *Edad*

Address: ____ Apt. ____________
Dirección *Apartamento*

City: ______________________State: ______ Zip: __________ Home phone : (___)-______-______
Ciudad *Estado* *Código Postal* *Teléfono de casa*

Cell phone: (____)-______-______ Social Security (Last four digits) -________ Email: _______________
Celular *Ultimos cuatro digitos del social security* *Correo electrónico*

Marital Status:__ Married __Single __Divorced__ Widowed__ Separated Gender:___ Male ___ Female
Estado Civil *Casado* *Soltero* *Divorciado* *Viudo* *Separado* *Género* *Masculino* *Femenino*

EMERGENCY CONTACTS *(Contactos de emergencia)*

FAMILY OR FRIEND CONTACT: (*Contacto del miembro de familia o amigo(a)*
Name: ________________________Last Name: _____________________ Phone: (__) ______-______-_____
Nombre *Apellido* *Teléfono*

PRIMARY DOCTOR CONTACT: (*Contacto del médico primario*)
Name: ________________________Last Name: _____________________ Phone: ( ) ______-_____-_____
Nombre *Apellido* *Teléfono*

PHARMACY CONTACT: (*Contacto De Farmacia*)
Name: ____ Phone: ( ) ______-_____-_____
Nombre *Teléfono*

INSURANCE INFORMATION *(Información del seguro médico)*

Insurance Company: ____ Member ID # ______________________
Primera compañía del seguro médico *Numero de Miembro*

Name of Policy Holder: ____ Date of Birth: ____/____/____
Nombre del asegurado *Fecha de Nacimiento*

Secondary Insurance Company: ________________________________ Member ID # ______________________
Primera compañía del seguro médico *Numero de Miembro*

Name of Policy Holder: ____ Date of Birth: ____/____/____
Nombre del asegurado *Fecha de Nacimiento*

Benefit Assignment & Acknowledgement of Financial Responsibility

I authorize the Insurance mentioned earlier to make payment directly to the Cardiovascular Institute of Orlando for the Medical Services I receive. I understand that I am financially responsible for all non-covered services, co-pays, co-insurance, deductibles, and other charges my insurance company deems my responsibility. If my account becomes delinquent for a period of (30) days or more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs and/or attorney's fees that may be incurred in the collection of my depth. *Yo autorizo a mi compañía de seguros para hacer el pago directamente a Cardiovascular Institute of Orlando por los servicios médicos que reciba. Entiendo que soy financieramente responsable de todos los servicios no cubiertos, co-pagos, co-seguros, deducibles y otros gastos que mi compañía de seguros considera que son mi responsabilidad. En caso de que mi cuenta se convierta en delincuente por un periodo de (30) días o más, reconozco que seré responsable de el saldo completo, intereses, costos judiciales y/o honorarios de abogados que puedan incurrir en la colección de mi deuda.*

Signature ____ Date: _____/_____/_______
Firma Fecha

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as my healthcare provider, this organization originates and maintains health records describing my health, symptoms, examinations and test results, diagnosis, 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 have been provided with a notice of Privacy Practices that gives a complete description of information uses and disclosures as a description of my privacy rights. I understand that I can review the note before signing these acknowledgments. I know that the organization reserves the right to change its notice and practices and will provide me with a copy of any revised information.

Patient Name: ______________________________ Witness: ___________________________________

Signature ____ Date: _____/_____/_______
Firma Fecha

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FINANCIAL POLICY

The Cardiology Institute of Orlando has a responsibility to provide quality healthcare services to patients. In maintaining a good patient relationship and continuing the delivery of quality healthcare, we hope you will take responsibility for your financial obligation to our practice. The following are general policies we have established for our patients, which allow some patients flexibility. We encourage you to discuss your account and any payment arrangement that you desire with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1- INSURANCE - As a courtesy to our patients, we file claims of all visits and procedures, either they are delivered in our office or in the hospital. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to the Cardiovascular Institute of Orlando. That is, the insurance company will pay the Cardiovascular Institute of Orlando directly). You are responsible for the payment of all deductibles, co-insurance, co-pays, and non-covered services. Please remember that insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payments to your doctor rests with you.

2- REFERRALS - You are required to know whether or not your insurance requires a referral/authorization and obtain that referral/authorization before you are scheduled to see our physicians. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor you wish to see and your coverage benefits. Referral typically has an expiration date and a limited number of visits, so you should be careful to monitor dates and visits. Our office will not see a patient who does not have a visit referral.

3- PROCEDURES - No show for procedures; your account will be charged an administrative fee of $100.00

4- APPOINTMENTS - New patients “No-show will be charged an administrative fee of $50.00

5- RETURNED CHECKS - Your account will be charged $30.00 for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and the fee.

6- PAST DUE ACCOUNTS - Patients who have not made an effort to make payment arrangements to have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their accounts to be turned into an agency will be expected to satisfy their financial obligation and pay for any future services in advance before being seen by our physicians.

7- NON-COVERED SERVICES - You have scheduled a visit with one of our physicians and physician believes to be relevant to evaluate, monitor, and protect your health. However, Medicare and certain other insurance companies will only pay for services that are determined to be “reasonably necessary”; they will deny payment for that service. Sometimes insurance companies will not cover an office visit before a procedure when the patient comes to the doctor with no symptoms and requests a screening procedure. Denial of payment by your insurance company does not mean that you need to visit a physician assistant beforehand.

Our doctors recommend an office visit prior to the performance of any procedure in order to have the patient’s general health evaluated and make sure the patient is well informed about the recommended procedure. We are required to notify you that your insurance company may not cover the office visit and that you will be responsible for payment.

PATIENT SETTLEMENT - BENEFIT ASSIGNMENT & ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I authorize the insurance mentioned before to make payments directly to the Cardiovascular Institute of Orlando for the medical services I receive. I understand that I am financially responsible for costs of all non-covered services, co-pays, co-insurance, deductibles, and any other charges my insurance company deems my responsibility. If my account becomes delinquent for a period of (30) days o more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs, and /attorney’s fees involving the attempt to collect the debt.

Signature ____ Date: _____/_____/_______
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name: ____ Date of Birth: ____/____/______
Nombre *Fecha*

Previous Name:________________________________ Social Security (Last four digits) - ________
Nombre Anterior *Ultimos cuatro digitos del social security*

I hereby request and authorize: ____ to release healthcare information pertaining to myself to the: (Yo autorizo a la oficina del doctor aquí mencionado, el divulgar información a acerca de mi estado de salud a:)

The Cardiovascular Institute of Orlando
812 W. Oak St. Kissimmee, FL 34741
1111 S. Semoran Blvd. Orlando, FL 32807
Office: (407) 201-3686 (407) 480-4445
Fax: (407) 201-3739 Fax: (407)480-4446

This authorization applies to the following: *(Esta información únicamente a lo siguiente)*
All Healthcare information relating to eh following treatment, condition with respective dates: *Toda información médica en relación a mi condición, tratamiento con fechas*

____
____

All Healthcare information generated by the Cardiovascular Institute of Orlando: *Toda información generada por Cardiology Institute of Orlando*

____
____

All Records:
Todos los expedientes médicos

____
____

Definition of sexually transmitted disease (STD) as defined by law, RCW 70.24, et.seq., includes herpes, herpes simplex, human papillomavirus, wart, genital warts, condyloma, chlamydia, non specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. *Definición de enfermedades de transmisión sexual (ETS) como lo define la ley, RCW 70.24, et.seq., incluye herpes, herpes simple, virus de papiloma humano, verrugas, verrugas genitales, condilomas, clamidia, uretritis inespecífica, sifilis, VDRL, chancro blando, linfogranuloma, venéreo, VIH (Virus de Inmunodeficiencia Humana), SIDA (Síndrome de inmunodeficiencia adquirida, y gonorrea.*

Yes___ No___ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. *Yo autorizo la entrega de los resultados de mi enfermedad de transmisión sexual, VIH/SIDA, ya sea negativa o positiva, a la persona(as) mencionadas anteriormente. Yo entiendo que la persona(s) mencionada anteriormente se le notificara que tengo que dar permiso por escrito antes de divulgar las pruebas y resultados.*

Yes___ No___ I authorize the release of my records regarding drug, alcohol, or mental health treatment to the person(s) listed above. *Yo autorizo divulgar todos los registros con respecto al consumo de drogas, alcohol y tratamiento de salud mental a las personas mencionadas anteriormente.*

Signature ______________________________________ Date: _____/_____/_______
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24 HOUR NOTICE FEES

The following policies have been designed to ensure efficient operation of the medical practice and to be fair and equitable to all of our patients. We require that any cancellation or rescheduling of appointments be made at least 24 hours in advance. Your cooperation with these stated policies enable us to focus our attention on your medical needs to better serve you: *(Las siguientes políticas han sido diseñadas para garantizar un funcionamiento eficiente de la práctica médica y para ser justas y equitativas para todos nuestros pacientes. Requerimos que cualquier cancelación o reprogramación de la cita se realice con al menos 24 horas de anticipación. Su cooperación con estas políticas establecidas nos permite centrar nuestra atención en sus necesidades médicas para servirle mejor)*

Missed nuclear stress/PET Scan/Vein Procedures …….……………………………..….. $250
Citas pérdidas de exámenes de esfuerzo y procedimiento de venas
Missed ECHO/Stress ECHO/Vein US ……….……………………………………………. $50
Citas perdidas de Echocardiogram/Stress ECHO y Ultrasonido de venas
Disability ………………………………………………………………………..……..…. $25
Discapacidad
Life Insurance……………………………………………………….………….…...…. $25
Seguro de vida
Jury duty………………………………………………………………………………… $25
Servicio de jurado
DMW Placard…………………………………………………………………..……..… $25
Cartel de DMW
Assisted living……………..……………………………………………………….…. $25
Forma para vida asistida
Typed letters (any reason)………………………………………….…………………...…. $25
Cartas para cualquier propósito
Medical records……………………………………………………….………..…. $25
Registros medicos
Copies of test images……………………………………………………….…..... $25
Copias de Exámenes
Statement re-billing…………………………………………………………..…....…. $5
Return Check ………………………………………………………..……….…..….. $25
Cheques devueltos

I understand that these are services not covered by my insurance which I will be responsible for.
(Entiendo que estos servicios no son cubiertos por mi aseguranza medica y por los cuales yo seré responsable)

Signature ____ Date: _____/_____/_______
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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date ____/____/ 20____

THE PATIENT: This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: ___________________________________ Date of Birth: ____/____/______
Nombre *Fecha*

THE PATIENT: This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

AUTHORIZATION: I authorize __________________________________ (“authorize party”) to use or disclose the following :(check one)

_______ - All of my medical related information
_______ - My medical information ONLY related to : ____
_______ - My Medical related information from ____/____/______ to ____/____/______
_______ - Other

Hereinafter known as the “Medical Records.”

ACKNOWLEDGEMENT OF RIGHTS

I understand that I have the right to revoke the authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke the authorization if its purpose was to obtain insurance

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that medical records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIpaa Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is valid as the original.

Signature ____ Date: _____/_____/_______
Firma Fecha