TREASURE COAST CARDIOVASCULAR INSTITUTE Inc
Arley Peter, MD, FACC
Phone: 772-999-3996 • Fax: 1866-506-8393 • www.treasurecoastcardio.com
1285 36th Street Suite 200B, Vero Beach, FL 32960

Patient's Name: _____ Sex: Select your sex Date of Birth: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Street Address: _____

City: _____ State: _____ Zip: _____

Secondary Address: _____

Home Phone: _____ Work Phone: _____ Social Security: ____ - ____ - ____

Cellphone: _____ Email: _____

If you do not wish to provide your email, select the reason: ◯ I do not want to be web enabled ◯ I do not want to share my email

Employment Status: Select a Status Employer's Name: _____

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Refuse to report

Race:

- ☐ American Indian or Alaska Native Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ Refuse to Report
- ☐ White
- ☐ Hispanic
- ☐ Other Race
- ☐ Other Pacific Islander

Preferred Pharmacy location: _____ Primary Care Physician: _____

Do you have Advanced Directives: ◯ YES ◯ NO DNR: ◯ YES ◯ NO Living Will: ◯ YES ◯ NO

Medical Power of Attorney: ◯ YES ◯ NO

Emergency Contact: _____ Relationship: _____ Phone: _____

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Authorization For Release Of Health Informationtion ion

DATE: _____

PATIENT NAME:_____

Date of Birth: _____ Social Security No: _____

Home Phone Number: _____ Cell Number: _____
Purpose of disclosure: ◯Continuation of care

Send records via including demographics, office visits, cath report, echo reports, stress test, ekgs, labs, any other imaging testing, hospital records _____

I hereby authorize that **Treasure Coast Cardiovascular Institute to RELEASE / OBTAIN** (circle one) **the protected health information regarding the above named person to / from:**

Person/Institution:_____
Address: _____ City:_____State:_____Zip: _____
Phone: _____ Fax:_____

I acknowledge and hereby consent to such that the released information may contain sexually transmitted diseases, alcohol and drug abuse, psychiatric or mental health services, HIV testing, HIV results or AIDS information. _____(**Initials**)

I understand that:
I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I may refuse to sign this authorization and that it is strictly voluntary.

If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise (see Signature section).
I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation or when the law provides for my insurer to have the right to contest a claim under my policy. Further details can be found in the Notice of Privacy Practices.
If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
I may see and obtain a copy of the information described on this form for a copy fee if I ask for it.
I get a copy of this form after I sign it if requested.

_____ (Patient/Guardian/Patient Representative)
(Signature/Date)
_____ (Patient/Guardian/Patient Representative)
(Print Name/Date)
_____ (Guardian/Patient Representative)
(Relationship to Patient)

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NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) **This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your Individually Identifiable Health Information. Please review this carefully.**

OUR COMMITMENT TO YOUR PRIVACY. Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following information:

-- How we may use and disclose your IIHI
-- Your privacy rights in your IIHI
-- Our obligations concerning the use and disclosure of your IIHI
The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses-may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our Practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL: 5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL: 6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL: 7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is

involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment for a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES. The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
-- Maintaining vital records, such as births and deaths
-- Reporting child abuse or neglect
-- Preventing or controlling disease, injury or disability
-- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
-- Reporting reactions to drugs or problems with products or devices
-- Notifying individuals if a product or device they may be using has been recalled
-- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
-- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
-- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
-- Concerning a death we believe has resulted from criminal conduct
-- In response to a warrant, summons, court order, subpoena or similar legal process.
-- To identify/locate a suspect, material witness, fugitive or missing person
-- In an emergency, to report a crime (including the location or victims(s) of the crime, or the description, identity or location of the perpetrator.

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organization that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (I) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only related to decedents and the researcher

agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access of the IIHI of the decedents.

8. Serious Threats to Health or safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

YOUR RIGHTS REGARDING YOUR IIHI. You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance you may ask that we contact you at home, rather than work. in order to request a type of confidential communication, you must make a written request to us and specifying the requested method of contact, other location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both, and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances,- however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice-, (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of

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disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as partof the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer then six (6) years from the date of disclosure. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI maybe revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.
Again, If you have any questions regarding this notice or our health information privacy policies, please contact us. TREASURE COAST CARDIOVASCULAR INSTITUTE 787 37TH street suite E260 Vero Beach FL 32960 Phone: 772 9993996.

NOTICE OF PRIVACY PRACTICES RECEIPT: We keep a record of the health care information related to you and we will not disclose your record to others unless you direct us or unless the law authorizes or compels us to do so. You may see your records or get more information about them by contacting office manager. **Notice of Privacy Practices** describes in greater detail how your health information may be used and disclosed, and how you can access your information. **By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

Patient or Legal Caregiver Signature: _____ Date: _____/_____/_____

Name: _____

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MEDICARE QUESTIONNAIRE AND PRIVATE PRACTICE DISCLOSURE

Medicare Secondary Payer (MSP) regulations require the practice to gather the following information to determine if Medicare is your primary insurance:

1. Is the illness covered by the Black Lung Program or Veterans Administration?

○Yes○No

2. Is the Illness/injury due to an automobile accident, liability accident, or Workers' Compensation?

○Yes○No

3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? □

○Yes○No

4. If under age 65, is your Medicare coverage due to disability?

○Yes○No

5. Is patient covered by a large group health plan through patient's employer or Spouse's current employer?

○Yes○No

6. If 65 and over is patient covered by Employer Group Health Plan through patient's or Spouse's employer?

○Yes○No

Patient or Legal Caregiver Signature: _____ Date: _____/_____/_____

Name: _____

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PAYMENT POLICIES
Please read the following payment policies

Please bring all pertinent insurance information and your insurance cards with you on each visit to our office. Also we recommend that you bring your preferred method of payment (credit card, check or cash) to pay for deductibles or co-pays. Your co-pay or deductible must be paid at the time of service.

Our office files your insurance as a courtesy. We recommend that you should review and understand your insurance policy. Your insurance policy is a contract between you and your insurance company. It is not a contract between you and our Doctors.
Should your insurance carrier withhold payment or partial payment of your claim for any reason, we will be glad to assist you in obtaining an explanation from them. However, we cannot guarantee payment of your claim. Also, we cannot be responsible for negotiating fees or claims with insurance companies or any other entity. Patients are responsible for payment of medical care within a reasonable time, regardless of the status of the claim.
If pre-authorization is needed, then it is your responsibility to notify our staff so we may obtain authorization. If no authorizations are on file we cannot provide the services unless you decide to pay for visit at self-pay rate. Patient balances are expected to be paid in full.
We do not have payment plans for outstanding balances. Partial balance payments through the mail will not be accepted.
If you have any questions or are not prepared to pay for your appointment, please notify one of our staff prior to your appointment. If you are unable to pay for residual balances from previous dates of services, you may be asked to reschedule your appointment.

There is a $50.00 fee for **missed appointments** (unless a 24-hour notice is given) or more than 15min late arrival.

There is a $25.00 fee for **returned checks or declined credit card.**

There is a $ 25.00 for **printing medical records** (first 100 pages then additional 30cents/per page).

There is a **placement fee** of thirty dollars ($30.00) in addition to the balance subject to collection.

By my signature below I acknowledge that I agree with Payment Policies.

Patient Signature: _____ Date: ____/____/____

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OFFICE POLICIES

New Patients: New patients to our practice and patients following up from hospital can complete new patient paperwork prior to appointment.

We welcome new patients for consultations. You may contact us directly or through a referring physician.

Please make sure to forward copies of your medical records from other physicians before your first appointment, which will be set for the earliest time and date possible.

Please print the new patient packet supplied and bring the completed forms with you to our office. Please arrive approximately 15 minutes early to allow for parking and timely arrival.

Prior to your appointment: On your first appointment and all future appointments, please bring a list of all **medicines** you are presently taking (include all herbal and over the counter medication), **photo ID** and your **health insurance card(s)** and **method of payment** for co-pays/deductibles.

Pharmacy: Please call your pharmacy to see if the prescription has been filled prior to calling the office and call pharmacy directly for refills. For refills: pharmacy will fax the request to our office and it will be reviewed immediately. We cannot refill if you are not a current patient or have not come for follow up in more than one year. Prescriptions will not be filled on weekends/holidays or after hours.

Referrals: If a referral has been made to another physician and you do not hear from that physician's office within 2-3 days, please contact our office so that we can assist you in getting your appointment scheduled.

Laboratory Testing: Many times your physician will ask that you have "fasting" blood work .The definition of fasting is: nothing after midnight except water or medications. When the doctor orders blood work, please have it done no less than 1 week prior to your next appointment so that your lab results can be discussed with you when you come in.

After hours: Bringing your concerns to our attention during office hours will ensure the problem is dealt with sooner and a prompt follow-up is scheduled. For urgent matters, you should go to the Emergency Department for any medical emergencies.

Change of information: If you have any changes on your name, address, phone number or insurance, please notify us as soon as possible. We do not want such changes to affect your medical care.

Out of network: If your insurance plan is out of network, we will have to collect full payment at time of service. After service, we will send a claim to insurance and insurance will notify you how much of what you paid will be covered or not.

Balances, co-pays, deductibles: Your financial obligation is determined by your insurance and expected to be payed in full on day of service.

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AUTHORIZATION TO DISCUSS HEALTH AND MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____
PARENT OR LEGAL GUARDIAN: _____

If I am not present, I authorize Treasure Coast Cardiovascular Institute and staff to disclose my relevant health information with the persons named below.

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

I understand that this authorization is valid and in effect until such time as I withdraw it in writing or in person, or one year following date of signature.

I understand that I can revoke, update, or change this verbal authorization at any time in writing.

The termination to verbally release health and medical information is effective on the date the physician office receives it.

It does not apply to any information released prior to the date of receipt of the written termination.

__ I decline to name family members and/or friends who my providers and staff may discuss my health information with at this time.
However, I understand that I can always verbally authorize providers and staff to discuss health information with family members and/or friends or I may complete form at a later date.

_____ _____ _____
Signature of patient or legal representative/guardian Authority or relationship of representative Date

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MEDICAL CONSENT - ASSIGNMENT OF BENEFITS - RELEASE OF INFORMATION

I hereby authorize the physicians and staff of Treasure Coast Cardiovascular Institute to provide medical care for the herein named patient.

I hereby authorize Treasure Coast Cardiovascular Institute to release medical information from examination or treatment to any insurance, government agency providing benefits or other policies to process any claims on my behalf for payment.

I hereby assign and authorize my insurance carrier(s) to make payment directly to Treasure Coast Cardiovascular Institute for all services rendered.

I understand I will be charged an additional fee of:

1. Twenty-five dollars ($25.00) for any check or draft dishonored by any financial institution.
2. In the event of collection placement of my account, I understand that I will be charged a placement fee of thirty dollars ($30.00) in addition to the balance subject to collection.
3. There is a $50.00 fee for missed appointments (unless a 24-hour notice is given) or more than 15 min late arrival.
4. There is a $ 25.00 for printing medical records (first 100 pages then additional 30 cents/per page).

I hereby with my signature, understand that I am ultimately responsible for payment in full of all services rendered in the event my insurance carrier and or managed care plan denies payment in full or part of any services rendered.

Patient or Legal Care Giver Signature: _____

Name: _____

Date: _____