Atlantic Cardiology & Medical Specialists, PA

Ahmad Shamsin, MD, FACC

Board Certified in Cardiovascular Disease

Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____

Home Address: _____ City/State: _____ Zip Code: _____

Next of Kin Name/Relation: _____ Contact Number: _____

Primary Care or Referring Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Primary Insurance/ID#: _____

Policy Holder Name/Relation: _____ Policy Holder Date of Birth: _____

Secondary Insurance/ID#: _____

I hereby instruct and direct my insurance company to pay by check made out and mailed to ATLANTIC CARDIOLOGY & MEDICAL SPECIALISTS PA. If my current policy prohibits direct payments to the practice, I hereby also instruct and direct you to make out the check to me and mail it to the temporary address as follows: PATIENT NAME, c/o ATLANTIC CARDIOLOGY & MEDICAL SPECIALISTS PA, 731 Dunlawton Ave, Suites 101-102, Port Orange, FL 32127. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I authorize the practice to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my status or above information and understand that if for any reason the insurance information provided is incorrect, I am fully responsible for any professional services rendered. I also agree that if my insurance requires an authorization for services, I am ultimately responsible for making sure the proper authorization is received prior to any service being provided.

_____ _____

Patient Signature Date

_____

Employee as Witness

731 Dunlawton Avenue, Suites 101 & 102
Port Orange, FL 32127

1180 W. Granada Boulevard, Suite D
Ormond Beach, FL 32174

386.767.9585 • Fax 386.767.9769

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FINANCIAL POLICY

Welcome and thank you for choosing Atlantic Cardiology & Medical Specialists for your medical care. We are committed to providing the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill. Payment in full is due at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Visa, MasterCard, Discover, and American Express. In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy:

- Please inform the receptionist of any demographic changes (phone number, address, insurance, change in primary care physician, etc). Failure to do so may result in you being responsible for any services not covered by your insurance carrier.
- It is your responsibility to verify that the physician is currently under contract with your insurance plan and that you have obtained all necessary referrals BEFORE your scheduled appointment. Failure to do so may result in you being responsible for any and all charges.
- Your insurance coverage benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
- Any services provided by a lab or outside facility is a contract between you and that facility. Any dispute should be handled between you and that facility and is not the responsibility of our practice.
- 24 hour notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a $35 no show fee for appointments and $150 no show fee for nuclear stress test.
- There will be a $30 return check fee and all future monies due must be paid in cash and/or credit card only.
- All past due balances are due prior to additional services being rendered unless other arrangements have been made.
- Our office is happy to work with you in order to pay any balance due to our practice and you can contact our billing department to work out a payment plan.
- Any balance over 60 days from the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency or attorney may be subject to a collection fee of 25%, which will be added to your total balance due.
- Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from our practice.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Witness

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I, _____Acct# _____,
authorize Atlantic Cardiology & Medical Specialists to access my medication records from my pharmacy.

_____

Patient Signature

_____

Date

_____

Witness Signature

_____

Date

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Authorization to Release Medical Records

PATIENT NAME: _____ DOB: _____

I authorize records be released from: _____

_____

I authorize records be released to: _____

_____

Medical records should include dates of _____ to _____

Please include the following records:

- o History & Physical/Consultation/Most recent office notes
- o EKG
- o Echocardiogram
- o Carotid Doppler
- o Stress test
- o Cardiac catheterization/coronary intervention
- o Cardiac operative reports (i.e. pacemaker, bypass, etc)
- o Most recent labs
- o Other: _____

_____ _____

Printed Patient Name Patient Signature

_____ _____

Date Witness

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Ahmad Shamsin, M.D., FACC

HIPPA Compliance or Release of Medical Information

I, _____, give authorization to release my medical information in the event that the below family member(s) call Atlantic Cardiology & Medical Specialists PA. If a name is not listed, no information can be released without the patient's written consent.

Name & Relationship: _____

Name & Relationship: _____

Name & Relationship: _____

I, _____, give authorization to Atlantic Cardiology & Medical Specialists PA to release my medical records to the treating physicians listed below.

Physician Name & Phone Number: _____

Physician Name & Phone Number: _____

Physician Name & Phone Number: _____

_____ _____

Printed Patient Name Patient Signature

_____ _____

Date Witness

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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations & Acknowledgement of Receipt of Privacy Policy

I, _____, understand that as part of my healthcare, ATLANTIC CARDIOLOGY & MEDICAL SPECIALISTS PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination 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,
- 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 Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be uses or disclosed to carry out treatment, payment or healthcare operations.

I understand that ATLANTIC CARDIOLOGY & MEDICAL SPECIALISTS PA 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 also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ATLANTIC CARDIOLOGY & MEDICAL SPECIALISTS PA reserves the right to change their notice and practices and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should ATLANTIC CARDIOLOGY & MEDICAL SPECIALISTS PA change their notice, they will send a copy of any revised notice to the address I have provided.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Printed Patient Name Patient Signature

_____ _____

Date Witness

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Ahmad Shamsin, MD
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Patient Name: _____ Age_____ Appointment Date _____ ☐ Male ☐ Female

Name of Primary Care (Family) Physician_____

Pharmacy Preference (include location) _____Height_____Weight_____

Are you taking ANY kind of medication now? ☐ No ☐ Yes If yes please list below.

Medication Name	Dosage

Are you allergic to any medications? ☐ No ☐ Yes If yes please list below

Medication Name	Type of Reaction

Non-Medication Allergies

Are you allergic to any food? Specify_____ Type of reaction_____
Are you allergic to any non-medical things such as latex, tape, metal? ☐ No ☐ Yes
If yes, specify_____ Type of reaction_____
Are you allergic to contrast dye? ☐ No ☐ Yes Iodine/Betadine? ☐ No ☐ Yes

SURGERIES AND HOSPITALIZATIONS.
Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No
If yes, please list type of problems: _____

List any surgeries you have had (including dates):

Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No
If yes, list reasons for hospitalizations _____

Patient Health History

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ● Incorrect Marks ⊘ ✓ ✗

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DIRECTION OF FEED

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	○	Metal	○
Iodine	○	Seafood	○
Latex	○	Contrast Dye	○

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	○	Gastrointestinal Reflux	○
Lung Cancer	○	Hepatitis	○
Skin Cancer	○	Stomach Ulcer	○
Throat Cancer	○		
Prostate Cancer	○		
Other Cancer	○	Are you pregnant?	○
		Prostate Enlargement	○
Migraine Headache	○	Renal Failure	○
Cataracts	○	Stroke	○
Glaucoma	○		
		Anxiety	○
Nasal Allergies	○	Depression	○
Sleep Apnea	○	Diabetes	○
		Thyroid Dysfunction	○
Blood Clots/DVT	○		
High/Elevated Cholesterol	○	Anemia	○
		Hemophilia	○
Heart Attack	○		
High Blood Pressure	○	HIV	○
Asthma	○		
Chronic Bronchitis	○		
Emphysema	○		
Tuberculosis	○		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	○	○	○	○	○
Thyroid Cancer	○	○	○	○	○
Lung Cancer	○	○	○	○	○
Unspecified Cancer	○	○	○	○	○
Hearing Loss before age 20	○	○	○	○	○
Hearing Loss after age 20	○	○	○	○	○
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
Asthma	○	○	○	○	○
Stroke	○	○	○	○	○
Diabetes	○	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○	○

4. Mark if retired. Yes ○

5. Tobacco Use:

Mark your tobacco use.

○ None ○ Cigarettes
○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoke in an average day.

○ 1/2 pack ○ 2 packs
○ 1 pack ○ 3 packs
○ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

○ Less than 12 drinks/yr
○ 1-13 drinks/mo
○ 4-14 drinks/wk
○ >2 drinks/day

6. Do you use drugs recreationally? Yes ○

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

○ None ○ 2-3 per day
○ 1 per day ○ 4 or more

8. Are you exposed to second hand smoke? Yes ○

9. Mark if patient attends daycare. Yes ○

10. Will you accept transfusion of blood products if necessary? Yes ○

11. Home Living Situation (mark all that apply).

○ Alone ○ With spouse
○ With children ○ In nursing home
○ With mother ○ With father
○ In assisted living ○ Other

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12. Do you now have or have you recently had any of the following?

	Yes
Fever	○
Sleeping problems	○
Unintentional weight loss	○
Unintentional weight gain	○
Blurred vision	○
Itchy eyes	○
Loss of vision	○
Painful eye	○
Dizziness	○
Ear drainage	○
Hearing loss	○
Ear pain	○
Ringing in the ears	○
Nasal congestion	○
Frequent nosebleeds	○
Post-nasal drainage	○
Belching sour material into throat	○
Hoarseness or other voice changes	○
Mouth ulcers	○
Partials or dentures	○
Blacking out or fainting	○
Chest pain	○
Heart murmur	○
Irregular heartbeats	○
Leg cramps	○
Swelling of ankles	○
Frequent non-productive cough	○
Frequent productive cough	○
Shortness of breath	○
Snoring (excessive)	○
Wheezing	○
Abdominal pain	○
Diarrhea	○
Heartburn	○
Nausea	○
Trouble swallowing	○
Painful swallowing	○
Vomiting	○
Painful joints	○
Stiffness in joints	○
Swelling of joints	○

12. Do you now have or have you recently had any of the following? *(continued)*

	Yes
Change in sense of smell	○
Change in sense of taste	○
Headache	○
Severe face pain	○
Seizures	○
Tremor	○
Appetite is increased	○
Fatigue	○
Cold feeling	○
Bleed excessively after injury	○
Bruise easily	○
Masses (lumps) in armpit	○
Masses (lumps) in neck	○
Masses (lumps) in groin	○
Hives	○
Sneezing	○

Thank you for completing this questionnaire!