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The Heart INSTITUTE

www.theheartinst.com

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Robert C. Sheppard, MD, FACC, FHRS

Dear New Patient,

Welcome to our practice! We are very pleased that you have selected us for your medical care. The Heart Institute is one of the largest cardiovascular groups in the Tampa Bay area, with 15 cardiologists and over 80 employees. Our programs span the entire spectrum of cardiovascular medicine. We have forged new frontiers of cardiovascular care and treatment through advances in nuclear medicine, cutting edge technology and research, and the development of preventive and educational services. Coupled with highly trained physicians and medical staff, The Heart Institute has established itself as a "Center of Excellence" in the care and treatment of cardiovascular disease.

Enclosed are forms for you to fill out in advance of your appointment to assist our office in making sure that we have all the information necessary to provide you with quality care and treatment. Please complete the forms and bring an updated medication list with you to your appointment to help speed up the check-in process. We will need you to arrive for your appointment 20 minutes prior to the appointment time so that we can get all the paperwork together and set up your chart to be ready for your appointment time. If you have been treated by a physician or hospital for the reason you are visiting us, then you may want to request copies of pertinent medical records in advance of your appointment or let us know so we can request them.

If you have insurance, please bring your most current insurance identification cards to your appointment. We must copy both sides of the card(s) and your driver's license for your record. If you belong to an HMO insurance, a proper referral is required from your primary care physicians' office. If you do not have a valid referral, you may be required to reschedule your appointment.

Thank you for choosing our practice. On behalf of our entire staff we look forward to seeing you and we will do everything we can to earn and keep the trust you have placed in us.

Sincerely,

The Heart Institute

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

The Heart Institute
Patient Financial Policy

The Physicians of The Heart Institute desire to serve the cardiology needs of the community effectively and as compassionately as possible within the bounds of prudent fiscal management. The Heart Institute is committed to providing the highest quality care, as well as being sensitive to our patients' financial situations. In order to provide state of the art care, The Heart Institute must charge appropriately for services and collect all amounts reasonably due.

As a courtesy, The Practice will assist all patients in filing their insurance claims. It is generally recognized that the patients' insurance policy is a contract between the patient and the insurance company.

Payment for services remains the patient's responsibility.

Patients arriving without verifiable insurance will be treated as self-pay until billable insurance information is obtained.

PAYMENT EXPECTATIONS AT TIME OF SERVICE

Unless other arrangements have been made, payment for co-pays and deductibles is expected at the time of the visit. Payment may be made by cash, check (in-state only), MasterCard, VISA, Discover, or American Express. Patients with no insurance will be expected to pay at the time of service and will receive a 35% discount on our fees.

A. Patients covered by:

Medicare – The Heart Institute is a Participating Provider with Medicare. This means we accept the Medicare allowed amount for our services. Medicare pays 80% of the allowed amount and we will look to the patient or their secondary insurance for payment of the remaining 20% co-insurance.

- Medicare patients without supplemental insurance will be expected to pay their 20% co-insurance at check out.
- Medicare patients with supplemental insurance will not be asked to pay at the time of service. Medicare generally sends the claim to the secondary carrier. After secondary insurance payment is received, the patient is expected to pay any remaining balance.
- Services not covered by Medicare are the patient's responsibility. The patient will be asked to sign an Advanced Beneficiary Notice (ABN) and expected to pay for those services in full at the time they are rendered.

Other Commercial Insurance Plans – The Heart Institute participates in many commercial Health Plans. Patients covered by any Health Plan **with which we participate** will be expected to pay any co-pay and deductible amounts at the time of service. The Heart Institute will submit a claim to the carrier for the remainder. The patient is expected to pay any deductible, co-insurance, non-covered, or non-authorized amounts as determined by the plan. **If The Heart**

Institute does NOT participate in the plan, the patient will be considered self-pay and expected to pay for services accordingly.

Note: Except in those cases when the physician specifically has the responsibility to pre-authorize a service, the patient is responsible for obtaining such authorizations, second opinions, etc. The Heart Institute will do everything it can to assist the patient in obtaining the necessary authorizations, including calling the primary care physician or plan on the patient's behalf. Patients presenting for non-emergency treatment without the required visit authorization, and practice is unable to obtain such authorization at the time, will be asked to either reschedule the appointment until the authorization can be obtained or to sign accepting financial responsibility for the visit.

Workers Compensation – The Heart Institute does not accept new Worker's Compensation cases at this time. We will continue to follow existing Worker's Compensation patients.

INSURANCE FILING

A. To ensure that insurance is filed properly, and with assignment of benefits, The Heart Institute will file insurance with appropriate authorization from the patient.

B. Patient will be expected to provide the following:
   a. Current insurance cards
   b. Any specific claim forms required by their insurance company
   c. Any pre-procedure or pre-certification requirements of their policy
   d. Signed authorization to release information and to assign benefits to the physician

C. Since there are many different types of insurance coverage we cannot address specific coverage issues for each carrier. **The patient must be familiar with their coverage**. Recognizing that some patients may need assistance in this task, whenever possible The Practice will help such patients determine insurance benefits.

D. The Heart Institute will do its best to submit an insurance claim on the patient's behalf correctly and in a timely manner, providing supporting documentation and promptly responding to inquiries when necessary. The Heart Institute cannot "guarantee" to a patient that insurance will cover any service.

E. The Heart Institute will send patient statements monthly until the balance is resolved. This not only allows the patient to monitor the activities of the insurance carrier but also reinforces the patient's responsibility for the account. Exception to the above:

- No statement will be sent to Medicare, Medicaid or HMO/PPO patients until after payment or other response has been received from the insurance carrier.

F. The Heart Institute of Florida will follow up all unresolved insurance claims within 45 days from the claim filing date as to the claim status. If an error was made in submission, it will be corrected and re-filed in a timely manner.

G. Claims denied or paid poorly will be researched and sent back for review by Business Office staff.

H. The Heart and Vascular Institute of Florida, South will adjust contractually-mandated amounts as determined by the insurance company's Explanation of Benefits (EOB).

PAYMENT ARRANGEMENTS

A. If payment in full of an outstanding balance presents a hardship to the patient, The Practice may agree to an extended payment plan using pre-approved guidelines. Any patient balances are generally expected to be resolved within 120 days. Patient should request to speak with a member of the billing staff to create a payment plan.

B. Any Self-Pay (no insurance coverage) patient is eligible for a thirty five percent (35%) discount of our billed charges. The patient is expected to make payment in full at the time services are rendered.

C. Financial Assistance – Patients who are truly in financial hardship and willing to complete an Application for Financial Assistance describing their financial status **may** receive a portion, or all, of their balance reduced. This discount will be approved by management.

D. The practice reserves the right to refer any unresolved patient account balance to a Collection Agency for pursuit.

MISCELLANEOUS

A. Returned Checks (NSF Policy) – If a check is returned to The Heart Institute for insufficient funds, a $25.00 fee will be added to the patient's account. The patient is required to bring in the appropriate amount of cash to cover the returned check plus additional fees.

B. No show Appointments – Patients will, under the following circumstances, be charged a fee for any no show appointments not cancelled within 24 hours of their appointment:

1) Testing Fee for No Show of Nuclear Stress Test $100.00

C. Decisions regarding interpretation of or exceptions to these policies are the responsibility of the Administrator and Business Office Manager.

The Heart Institute
Patient Financial Policy

Acknowledgement of Receipt of Policy

I hereby acknowledge that I have received a copy of The Heart Institute's Patient Financial Policy.

Signed:_____Date:_____

Print Name:_____

If not signed by the patient, please indicate your relationship:

- ☐ Parent or Guardian of minor patient
- ☐ Guardian or Conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient:_____

For Office Use Only:

- ☐ Signed form received by: _____
- ☐ Acknowledgement refused:
  Efforts to obtain:

Reasons for refusal:

Assignment of Benefits and Financial Responsibility

I hereby assign to The Heart Institute any insurance or other third-party benefits available for health care services provided to me. I understand that The Heart Institute has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to The Heart Institute, I agree to forward to The Heart Institute all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

I acknowledge that I am responsible to pay any deductible, co-insurance or non-covered, amounts as determined by my insurance plan.

Consent to Telephone Calls for Financial Communications

I agree that, in order for The Heart Institute, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that The Heart Institute or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or The Heart Institute or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Signature of Patient/Legal Guardian/Patient Representative:

_____ Date:_____

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PATIENT REGISTRATION FORM

Name: _____ Sex: ❑M ❑F Date: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____ Cell Phone:_____

Email: _____

Date of Birth: _____ Age:_____ SS#: _____

Ethnicity:_____ Preferred Language:_____

Race: ❑American Indian or Alaska Native ❑Black or African American ❑Asian
❑Native Hawaiian or Other Pacific Islander ❑Unreported/Refused to Report ❑White

Emergency Contact: _____Phone: _____Relationship:_____

Address: _____ Do you have a Living Will? ❑Yes ❑No

Marital Status: ❑Single ❑ Married
❑Divorced/Separated ❑Widowed

Employed: ❑Full Time ❑Part-time
❑Unemployed ❑Disabled ❑Retired ❑Military

Employer: _____ Job Title: _____

Local Pharmacy Name: _____Phone: _____

Pharmacy Address: _____

Family Doctor: _____ Referring Doctor: _____

Insurance Card(s): Please present to receptionist to photocopy for file. ____ (check if completed)

Primary Insurance: _____Secondary Insurance: _____

I hereby authorize The Heart Institute to release all or part of my medical records to Medicare and/or any other companies, if requested, without any liability to The Heart Institute. I hereby authorize Medicare and/or my insurance companies to pay directly to The Heart Institute any payments, assignments or benefits due me.

_____Date: _____
Patient Signature

Rev: 10/16

Reason for Today's Visit?_____

PAST MEDICAL HISTORY:

Please list any previous illness, hospitalizations or surgeries, and the year:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any medications you are currently taking:

Name, strength, frequency

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

ALLERGIES **Do you have allergies to drugs, food, latex, dye?** ☐ **YES** ☐ **NO**

Allergy - list medication, food, latex, dye, etc.	**Reaction - rash, shortness of breath, hives, itching, etc**

Have you seen a cardiologist in the past? ☐ If "yes":

Name _____ Location _____

Have you been told you have:

☐ Angina, ☐ Mitral Valve Prolapse, ☐ Heart Murmur, ☐ TIA's, ☐ Diabetes, ☐ High Blood Pressure, ☐ Heart Attack (circle)
Date _____.

Have you ever had any of the following procedures? Please tell us when.

☐ Heart Catheterization _____ ☐ Angioplasty _____
☐ Coronary Bypass _____ ☐ Exercise Test _____
☐ Echocardiogram _____ ☐ Holter Monitor _____
Do you know your cholesterol level? _____

FAMILY HISTORY

Living	**Age**	**Health Status**
Father		
Mother		
Sisters		
Brothers		
Deceased	**Age at Death**	**Cause of Death**
Father		
Mother		
Sisters		
Brothers		

Do you have a Family History of?

Diabetes ☐ High Cholesterol ☐ ☐ Stroke Cancer ☐ Heart Attack ☐

Social History

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Number of Children? _____ Ages _____

Do you smoke? Yes ____ No ____ How much _____ How Long _____ Year Quit _____

Do you drink alcohol? Yes ____ No _____ how much per week? _____

Do you exercise? Yes ____ No _____What do you do? _____Frequency_____

Please circle if it applies to you:

Eyesight: ☐ Good - ☐ Fair - ☐ Poor - ☐ Glaucoma

Ears, Nose, Throat: ☐ Poor Hearing - ☐ Sore Throat - ☐ Sinus Problems

Gastrointestinal: ☐ Swallowing Problems - ☐ Indigestion - ☐ Ulcers ☐ Hiatal Hernia - ☐ Bloody stools - ☐ Diarrhea

Genitourinary: ☐ Difficulty Urinating - ☐ Blood in Urine - ☐ Prostate Problems - ☐ Kidney problems – ☐ Postmeno.

Musculoskeletal: ☐ Muscle Pain - ☐ Joint pain - ☐ Arthritis

Integumentary: ☐ Skin Rash - ☐ Skin Disorders

Neurological/Psychiatry: ☐ Fainting - ☐ Depression - ☐ Anxiety - ☐ Drug Dependence

Endocrine: ☐ Thyroid Disease - ☐ Diabetes

Hematologic/Lymphatic: ☐ Taking Blood Thinners - ☐ Taking Aspirin - ☐ Coumadin

Allergic/Immunologic: ☐ Sinusitis - ☐ Hayfever - ☐ Allergies

Please answer the questions in the following sections, if they apply to you

Chest Pain

Do you have Chest Pain? Yes ____ No ____ If *yes* answer questions 1-9. If NO move to the next section.

1. How long have you had chest pain? _____
2. Location of chest pain? _____
3. Radiation of chest pain: none, left arm, left shoulder, right arm, right shoulder, jaw, back (circle)
4. Character of pain: dull, pressure, heaviness, sharp (circle)
5. Duration of episodes: seconds, minutes, hours, constant (circle)
6. Severity of pain 0-10 (zero being pain free) _____
7. Do you have pain with: exercise, resting or both? (circle)
8. Do you have any of the following with your pain? shortness of breath, nausea, palpitations or sweating

Peripheral Arterial Disease

1. When you walk or exercise, do you experience discomfort (aching, cramping or pain) Yes/No
   A. If you answered yes, does the discomfort subside with rest? Yes/No
2. Have you ever had surgery, balloon procedures, or stents to any blood vessels other than your heart? Yes /No
3. Do you have painful sores or ulcers on your legs or feet that are not healing? Yes/No
4. Are your toes or feet pale, discolored, or bluish? Yes/No
5. Have you ever been told by a physician that you have poor circulation? Yes/No

Shortness of Breath

Do you have shortness of breath? yes ____ no ____ If *yes* answer questions 1-9. If *no* move to the next section.

1. How long have you had shortness of breath? _____
2. What makes you short of breath? _____
3. Do you wake up at night short of breath? never, rarely, every night (circle)
4. Do you get up to urinate at night? yes ____ no ____
5. Do you tire easily? yes ____ no ____
6. Do you have leg or ankle swelling? yes ____ no ____
7. Do you have wheezing? yes ____ no ____
8. Do you have a cough? yes ____ no ____ Sputum production? yes ____ no ____

Palpitations

Do you have palpitations? yes ____ no ____ If yes answer questions 1-5. If no move to the next section.

1. How long have you had palpitations? _____
2. Does your heart feel like: skipping beats, racing, beating fast & regular, beating fast & irregular? (circle)
3. Do your palpitations occur with any of the following: rest, exercise, excitement, alcohol, caffeine? (circle)
4. Are you under a lot of tension and stress? yes ____ no ____
5. Do you have other symptoms with your palpitations? none, dizziness, fainting, shortness of breath, nausea, sweating, lightheadedness (circle)

Patient Signature: _____ Date: _____

PHYSICIAN SIGNATURE: _____