

SOUTHSHORE CARDIOVASCULAR ASSOCIATES

REGISTRATION FORM

Today's date:				Primary Doctor:						
PATIENT INFORMATION										
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?			(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Street address:				Social Security no.:		Home phone no.: ()				
P.O. box:		City:			State:		ZIP Code:			
Pharmacy Name:		Pharmacy Address:				Pharmacy Phone #:				
Chose clinic because/Referred to clinic by (please check one box):					<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Other	<u>Email Address:</u>					
INSURANCE INFORMATION										
(Please give your insurance card to the receptionist.)										
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.: ()				
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No								
Occupation:	Employer:	Employer address:				Employer phone no.: ()				
Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance		<input type="checkbox"/> BCBS		<input type="checkbox"/> AETNA		<input type="checkbox"/> United Health		<input type="checkbox"/> Humana		<input type="checkbox"/> Medicare
<input type="checkbox"/> Optimum	<input type="checkbox"/> Care plus		<input type="checkbox"/> Freedom		<input type="checkbox"/> Other		<input type="checkbox"/> Other			
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /		Group no.:	Policy no.:		Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other				
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:		Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other				

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Southshore Cardiovascular Association or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

SOUTHSHORE CARDIOVASCULAR ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ DOB: _____ SS: _____
(Patient's Name)

Give: **Southshore Cardiovascular Associates**

**1159 Nikki View Dr.
Brandon, Fl. 33511**

**10726 Ketchum Valley Dr.
Riverview, Fl. 33579**

**12110 N 56th St
Temple Terrace, Fl. 33617**

Authorization to release my confidential information regarding my medical records and health information to the following individuals/family members:

Name	D.O.B.	Phone#	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature

Date

Witness

Date

IN CASE OF EMERGENCY

Name of local friend or relative
(not living at same address)

Home Phone No

Work Phone No

Relationship

SOUTHSHORE CARDIOVASCULAR ASSOCIATES

RELEASE OF MEDICAL RECORDS

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ Printed name of patient		_____ Social Security Number		_____ Date of Birth
_____ Street Address		_____ City	_____ State	_____ Zip code
_____ Signature of patient or representative		_____ Relationship to patient		_____ Expiration date
_____ Signature of Witness		_____ Today's Date		

MUST HAVE COMPLETED INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED

I hereby authorize the use and disclosure (release) of my medical records information from:

To:

Southshore Cardiovascular Associates

1159 Nikki View Drive
Brandon, FL 33511
Ph# 813-661-6199
Fax# 813-661-6334

10726 Ketchum Valley Drive
Riverview, FL 33579
Ph# 813-677-9200
Fax# 813-677-9224

12110 N. 56th Street
Temple Terrace, FL 33617
Ph# 813-988-2754
Fax# 813-661-6334

The medical record information will be used and/or disclosed for the following purposes:

- At the request of the individual
- Changing primary care physician
- Changing and/or seeing specialist
- Other _____

I acknowledge and agree that the term medical record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays, and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

I understand that this authorization shall remain in effect for a period of 90 days; I further understand that I may revoke this authorization at any time by notifying SSCA in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by SSCA before receiving my revocation.

SOUTHSHORE CARDIOVASCULAR ASSOCIATES

PATIENT HISTORY

Name: _____ PCP/Referring Physician: _____ Date: _____

CURRENT CARDIAC SYMPTOMS

Chest Pain or angina Y / N
 Palpitations (feel heart beating hard)..... Y / N
 Short of Breath (walking / lying flat)..... Y / N
 Swelling of Feet, Ankles, or HandsY / N
 Lightheadedness, Dizziness, or Fainting.....Y / N
 Pain in legs when walking.....Y / N

ALLERGIC/IMMUNOLOGIC

Penicillin or other antibiotics.....Y / N
 Morphine, Demerol, or other narcotics.....Y / N
 Aspirin or other pain remediesY / N
 Iodine, Methiolate, or shell fish..... Y / N
 Drugs / Medications _____

PAST MEDICAL HISTORY

Have you ever been told that you had

DiabetesY / N
 High Blood PressureY / N
 CancerY / N
 Stroke / Mini-Stroke / TIAY / N
 Heart Attack / AnginaY / N
 Kidney TroubleY / N
 Arthritis / Gout Y / N
 Convulsions / Seizures Y / N
 Bleeding TendenciesY / N
 Serious Infections..... Y / N
 Lung Diseases / Asthma.....Y / N
 Heart Murmur / Valve Disease..... Y / N

Previous Cardiac Hospitalizations / Heart Catheterization / Heart Attacks / Surgeries

_____ Date: _____
 _____ Date: _____
 _____ Date: _____

Cardiac Diagnostic Tests / Echocardiogram / Stress Test / Holter Monitor / Other

_____ Date: _____
 _____ Date: _____
 _____ Date: _____

MEDICATIONS: (currently taking)

Name of Medicine	Dose	How Often?	Name of Medicine	Dose	How often?
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

SOCIAL HISTORY

Use of Tobacco: Never / Previously Quit in _____ / Current: Cigar / Pipe / Cigarettes Amount: _____
 Use of Alcohol: Never / Moderate / Daily Amount: _____
 Use of Drugs: Never / Type of Drugs: _____ How Often: _____
 Use of Caffeine: Never / Moderate / Daily Type: _____ Amount: _____
 Exercise: Never / Moderate / Daily Type: _____ How Often: _____

FAMILY HISTORY

	AGE	DISEASE	IF DECEASED, CAUSE OF DEATH
Father	_____	_____	_____
Mother	_____	_____	_____
Brother/Sister	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
Children	_____	_____	_____
2.	_____	_____	_____

Demographic Questionnaire

To help assure quality care for all, federal mandates have been issued requiring capture of information on race, ethnicity and language data. New regulations from The Joint Commission, the Affordable Health Care Act, and CMS Medicare require physician offices to identify these health care disparities. By collecting this information, the federal government believes that it can ensure that all patients receive high-quality care.

We would appreciate it if you would complete this form. If there is any part you prefer not to provide, please mark the **Decline** checkbox.

Please return form to the front desk.

Thank you

Please check one item from each column:

Race	Language	Ethnicity
<input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Declined	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Indian <input type="checkbox"/> Russian <input type="checkbox"/> Other _____ <input type="checkbox"/> Declined	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Declined

Printed Name

Date of Birth

Signature

Date

SOUTHSHORE CARDIOVASCULAR ASSOCIATES

NOTICE OF PRIVACY PRACTICES

I have received, read, and understood the **NOTICE OF PRIVACY PRACTICES** for Southshore Cardiovascular Associates that have been provided for me by Southshore Cardiovascular Associates. I understand that if I have any questions I will contact the Privacy office regarding my concerns.

Patient Signature

Date

Witness

SOUTHSHORE CARDIOVASCULAR ASSOCIATES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**If you have any questions about this notice please contact
our Privacy Officer who is Sue Candiloro**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician’s practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **[describe how patient may obtain a restriction.]**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Sue Candiloro** at (813)661-6199 or **Info@southshorecardio.org** for further information about the complaint process.