* ATTENTION ALL PATIENTS *

PLEASE REMEMBER THAT ALL COPAY'S AND DEDUCTIBLE'S ARE DUE AT THE TIME OF YOUR APPOINTMENT.

BEGINNING JANUARY 1ST, 2016 PATIENTS WILL **NOT** BE SEEN WITHOUT PAYING THEIR COPAY OR DEDUCTIBLE. ALSO, ANY PAST DUE BALANCES ARE TO BE PAID PRIOR TO BEING SEEN OR YOUR APPOINTMENT *WILL BE RESCHEDULED,* **NO EXCEPTIONS.**

****** PLEASE COME 15 MINS BEFORE YOUR APPOINTMENT TIME & BRING ID AND INSURANCE CARDS ******

THIS IS OFFICE POLICY.

THANK YOU FOR YOUR COOPERATION.

Dear Patient,

Some of the patients who come to our office to be seen by one of our physicians are upset by what may seem like endless hours of waiting before being evaluated. We understand that a patient's time is valuable and we respect that. Therefore, we believe it would be helpful for you to understand our philosophy about patient care and, hopefully in some way, that may help in coping with the wait.

Many of the patients, who come to see us, have serious cardiac problems. Some of the patients already have a diagnosis and are referred to us for consideration of treatment alternatives. Others come to the office with complaints that require a diagnosis of a potentially life-threatening illness. There is often some degree of anxiety that accompanies an office visit. Consequently, it is our goal that patients can be seen quickly in the office. We want to be accessible to our patients. Since it is not unusual for a physician in our practice to see six to nine new patients during his clinic hours, in addition to the many follow-up patients, answering colleagues calls, and at times, attend to unscheduled emergency cases, keeping to the schedule may be often impossible. One alternative, of course, would be for each of us to restrict the number of patients seen in the office, and thus, alleviate the potential waiting time. But again, our policy, particularly for those who have a serious diagnosis, is to provide an appointment as soon as possible. As a result, patients may have to wait while another patient is being evaluated thoroughly and while the physician and patient make the best choice for treatment for each individual case. When it is your turn you will be given the same consideration from our physician and another patient may have to wait.

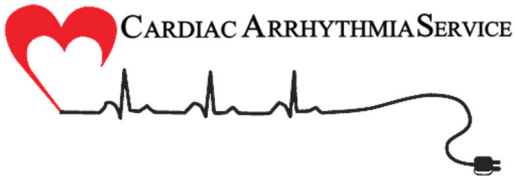
With regard to follow up appointments, you may at times be scheduled and seen by our very capable and well trained Physician Assistant. Physician Assistants are licensed to practice medicine as well as prescribe medications. They can perform history and physicals, pacemaker and ICD checks. When they work with doctors in this manner, they accelerate an essential part of the process and ensure that a most complete history and evaluation are performed. Ultimately all cases are reviewed by our physicians.

All of the individuals who are part of our team are committed to working hard and putting in the hours as needed to provide patients with the best possible care.

We will make every effort to provide the medical assistance you require and we hope that you are pleased with our quality of care. If, at any point, we do not meet your level of expectation, we hope that you will write or call your physician directly or contact, Michelle Olitzky, Office Administrator; so we know in what valuable ways we can improve our service to you.

CARDIAC ARRHYTHMIA SERVICE

Murray Rosenbaum, M.D., F.A.C.C., F.H.R.S.
E Martin Kloosterman, M.D., F.A.C.C., F.H.R.S.
Jonathan Rosman, M.D., F.A.C.C., F.H.R.S.
Melissa Trachtenberg, PA-C
Alyson Walsh, PA-C



1200 N. Federal Highway, Suite 100
Boca Raton, FL 33432
Tel: 561-266-0190 * Fax: 561-392-9781
www.backonrhythm.com

MALPRACTICE INSURANCE ACKNOWLEDGEMENT

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims from medical malpractice.

Your doctor has decided ***NOT*** to carry medical malpractice insurance.

This is permitted under Florida Law subject to certain conditions.

In signing I acknowledge that I am aware that Cardiac Arrhythmia Service has elected not to carry Medical Malpractice Insurance.

Signature _____

Date _____

Murray Rosenbaum, M.D., F.A.C.C., F.H.R.S.
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NEW PATIENT INFORMATION SHEET

Today's Date: _____

First Name: _____ Middle: _____ Last Name: _____

Race: _____ Ethnicity: _____ Date of Birth _____

Social Security Number: _____ Sex: Male Female Age: _____

Address: _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Cell _____ Work _____

Email _____ Work Number _____

Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Best Time to Reach You _____

Out of Town Address _____ Phone _____

Single Married Widowed Divorced Separated

Spouse's Name _____ Phone _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Cell _____ Work _____

Authorization & Release

**** PLEASE RETURN THIS FORM WITH YOUR INSURANCE CARD(S) SO THAT WE CAN MAKE COPIES ****

I, the undersigned certify that I (or my dependent) have insurance coverage

with _____

* I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and / or other health practitioners.
* I authorize and request my insurance company to pay directly to the doctor of doctor's group insurance benefits otherwise payable to me.

* I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then paid and owed may be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect the amount of any outstanding account balances.

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

Patient's Name _____

Insured's Name _____ Date of Birth _____

Relationship _____ Self _____ Spouse _____ Parent / Guardian

Insurance ID Number _____ Group Number _____

SECONDARY INSURANCE COMPANY _____

Patient's Name _____

Insured's Name _____ Date of Birth _____

Insurance ID Number _____ Group Number _____

Is this visit due to a work-related injury or an Auto Accident? _____ Yes _____ No Date of accident _____

***** If you answered YES to the question above, please allow us to make a copy of the accident report *****

Signature of Patient _____

Date _____

Do you or have you had any of the following? Please check or Circle All that Apply.

- Pacemaker
- Defibrillator
- Atrial fib
- Atrial flutter
- SVT
- Palpitations
- Heart surgery
- Replace heart valves
- Mitral value prolapse
- Angina/chest pain
- Heart attack
- Stroke
- Heart murmur
- High blood pressure
- Low blood pressure
- Rheumatic Fever
- Previous bacterial endocarditis
- Fainting/Dizziness/Syncope
- Vertigo
- Shortness of breath
- Family history of sudden death
- Immune problems
- HIV positive
- Cancer _____
- Chemotherapy
- Leukemia
- Liver disease
- Hepatitis
- Kidney disease
- Dialysis
- Loss of bladder control
- Anemia
- Excessive bleeding
- Bleeding problems
- Blood transfusion
- Hypoglycemia
- Thyroid disease
- Hormonal problems
- Lymphoma
- MRSA
- History of smoking
- Emphysema
- Tuberculosis
- Asthma
- Allergies
- Sinus trouble
- Intestinal disease
- Ulcers
- Arthritis
- Weight gain/loss unexplained
- Are you pregnant?
- Sexual Problems
- Depression/Anxiety
- Phobias
- Glasses/Contact lenses
- Hearing aids
- Psychiatric care
- History of alcohol abuse
- History of drug abuse

Have you ever been hospitalized or had a major operation in the past 5 years? **YES** **NO**

Have you ever had any other illness not listed above? **YES** **NO**

If yes, please explain _____

_____

Date of last physical examination _____

To the best of my knowledge all of the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the doctor at the next appointment.

PATIENT SIGNATURE _____ DATE _____

PATIENTS NAME _____

PLEASE LIST ALL MEDICATION ALLERGIES

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY

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

PHARMACY INFORMATION

Pharmacy Name _____

Address _____

Phone _____

REFERRING AND PRIMARY PHYSICIAN INFORMATION

Cardiologist _____

Address _____

Phone _____

Primary Physician _____

Address _____

Phone _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name _____

Address _____

Telephone _____ Social Security _____

Section B: To the Patient – Please read the following statement carefully

Purpose of Privacy Practices. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practice. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your information. A copy of our Notice is posted in our reception area. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting

Contact Office: **Cardiac Arrhythmia Service**
Address: **1200 N. Federal Hwy., Boca Raton, Florida 33432**
Telephone: **561-266-0190** Fax: **561-392-9781**

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the content of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatments, payment activities and healthcare operation.

Signature _____ Date _____

Patient Questionnaire and HIPAA Acknowledgement

Patient Name _____ Date _____

Home Tel_____ Work Tel. _____Cell Tel. _____

May we contact you at home? **Yes** **No**
May we contact you at work? **Yes** **No**
May we contact you on your cell phone? **Yes** **No**

If there is a phone message system may we leave a message for you at any of the contact numbers you have provided? **Yes / No**

Comment _____

Can a message be left with our company name and what the call is in reference to? **Yes** **No**

Is there anyone we can leave a message with? **Yes** **No** (If yes, please list first and last names as well as contact numbers)

_____

_____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. **Yes** **No** (If yes, please list first and last names as well as contact number)

_____

_____

Patient Signature _____ Date _____

Is there anyone you would like to designate as your personal representative that we may discuss your procedure, course of treatment and status. **Yes** **No** (If yes, please list first and last names as well as contact numbers)

_____

Patient Signature _____ Date _____

Cardiac Arrhythmia Service has provided me with a copy of my rights and a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

Patient Signature _____ Date _____

Witness _____