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, attending to unscheduled emergency cases, keeping to the schedule may often be 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 consequence, patients may have to wait as an accommodation.

All of the individuals who are part of our team are committed to working as hard and putting in hours needed to provide patients with the best possible care. You may have to wait while another patient is being evaluated thoroughly and while the physician and patient make the best choice for treatment. When it is your turn, you will have the same consideration from our physician and indeed another patient may have to wait.

With regard to follow-up appointments, you will be seen initially by one of our very capable and well-trained physician assistants. They will obtain your initial history and possibly perform a part of the physical examination and check your device. When they work with us 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.

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
Today's Date: ___________________________ Social Security Number: ___________________________

First Name: ___________________________ Middle: _________ Last Name: _____________________________

Race: _______________ Ethnicity: _______________ Date of Birth______/______/_____________

Address: ________________________________________________________________________________

City______________________________ State_________ Zip ________ County: ___________________________

Home Phone: _______________________ Alternate number: ________________________________

   Sex:    Male   Female     Age:______      Single   Married   Widowed   Divorced   Separated

Spouse's Name: __________________________________________________________________________

Occupation________________________ Employer:___________________________________________________

Employer Address: _____________________________ Employer Phone:____________________________

Out of Town Address: _______________________________________________________________________

IN CASE OF EMERGENCY CONTACT:

Name:_________________________________________ Relationship:______________________________

Home Phone: _________________________________ Alternate number: _____________________________

Referring Physician: __________________________________________________________

  Phone:_________________________________________________________________________________

Primary Care Physician: _________________________________________________________________

  Phone:_________________________________________________________________________________

Pharmacy Name: ________________________________________________________________

  Pharmacy Phone Number: ___________________________________________________________________
PRIMARY INSURANCE COMPANY NAME: ________________________________

Patient’s Name_________________________________________________________________________________

Insured’s Name_________________________________________________________________________________

Relationship: _____ Self  _____Spouse   _____Parent/Guardian

Insured’s Date of Birth :________________________

Insurance ID Number:__________________________  Group Number: ___________________________________

( If you have Medicare, what is Medicare Number): ____________________________________________________

SECONDARY INSURANCE COMPANY NAME: ________________________________

Patient’s Name_________________________________________________________________________________

Insured’s Name:_________________________________Date of Birth:___________________________________

Insurance ID Number: ____________________________Group Number:__________________________________

Is this visit due to work-related injury?   ____Yes                  _____No                            Date of accident __________

Is this visit due to an auto accident?    _____Yes                _____No                           Date of accident__________

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

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

Authorization & Release

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 that 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.

Signature of Patient:_______________________________________________ Date: _____/_____/___________
Name of Patient: ____________________________________________________________

List any medications you are allergic to: ____________________________________________________________________________________________
__________________________________________________________________________________________

Medications:

PLEASE LIST THE NAME AND HOW OFTEN YOU ARE TAKING THE MEDICATION
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
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__________________________________________________________________________________________
__________________________________________________________________________________________
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Giving Consent

Name:__________________________________________DOB:_______________________

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 you 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 Cardiac Arrhythmia Service at 561-266-0190.

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

Signature
I have had a full opportunity to read and consider the contents 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:______________
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: _______________________________________________________

HIPPA Acknowledgement

Please circle where we are able to contact you.   HOME    CELL    WORK    ALL

Is it ok to leave a message at the above numbers stating our company name and what the call is regarding?   YES ___________ NO ___________

Is there anyone you would like to authorize as your personal representative to be able to discuss course of treatment, procedures, and appointment information.

Name of patient representative: __________________________________________________

****I am aware that Cardiac Arrhythmia Service has a posted copy of Patient’s Bill of Rights and the HIPPA Privacy Notes in the waiting room for patients to read. A copy will be provided to any patient that requests a copy.****

Signature: ___________________________________________________ Date: ______________________
RELEASE OF RECORDS

Patient Name: ____________________________________________________

Date of Birth: ____________________________________________________

I authorize the release of my medical records including all office visit, hospitalization, diagnostic testing, and other written information concerning my health and treatment to be sent to:

Cardiac Arrhythmia Service
1200 N. Federal Highway Suite 100
Boca Raton FL 33432
Phone 561-266-0190   Fax 561-392-9781

Company to release records to Cardiac Arrhythmia Service

Name:______________________________________________________________

Address:________________________________________________________________

Telephone:___________________________________________________________

Fax:____________________________________________________________________

Patient Signature: ____________________________________________________