EFFECTIVE JUNE 1, 2023

PATIENT NO-SHOW & CANCELLATION POLICY

Your care and health are very important to us and we strive to ensure you are provided with excellent medical care. In order to be consistent with this, we have a **Patient No-Show and Cancellation Policy** in place for our patients.

When an appointment is scheduled, that time has been reserved for you and when it is missed or cancelled on short notice, that time cannot be used to see another patient. If you find that you are unable to make the appointment, it is necessary for you to notify us by phone at least 24-hours in advance of your appointment date and time. We will be happy to find an alternative time and date that better meets your needs.

There will be a **$35.00** fee charged directly to the patient /guarantor, NOT the patient's insurance, for those who either do not show up for their appointment or cancel with less than a 24-hour notice.

All No-Show and Cancellation fees must be paid prior to the next appointment in order to be seen.

In the event an unforeseen circumstance requires an appointment to be canceled without 24-hour's notice, the fees may be waived, provided the appointment is rescheduled for a future date.

CARDIAC ARRHYTHMIA SERVICE, INC.

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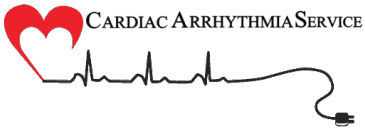

1200 N.Federal Highway, Suite 100
Boca Raton, FL 33432
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www.backonrhythm.com

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 wil 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

Where can we 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: _____