F.A.C.T.
Surgery

Florida Advanced Cardiothoracic Surgery

Name: ____ Phone: ____________________

Address: ____ Cell:____________________

City: ___________________________________ State: ______ Zip Code: ____________

Social Security #: ______-_____-_______ Date of Birth: ____/_____/_____ Age: _____

Emergency Contact: ___________________________ Phone: ______________________

Who can we thank for referring you to our office: ______________________________

Please tell us which physician(s) we should contact regarding your visit:

Primary Care Physician:	**Cardiologist:**
Name: ______________________________	Name: _______________________________
Address: ____________________________	Address: _____________________________
Phone: (_____)-_______________________	Phone: (_____)-_______________________
Fax: (_____)-_______________________	Fax: (_____)-_______________________

Please describe the reason you are seeking a consultation: _________________________

____

Allergies: ____

What medications do you take? Please Bring a List of Medications to your appointment.

Name of Medicine	Dose (mg)	How many times per day?

Review of Systems:

General: [ ] Weight gain [ ] Weight loss [ ] Weakness [ ] Fatigue
[ ] Fever [ ] None
[ ] Other ____________________

Eyes: [ ] Pain [ ] Redness [ ] Tearing [ ] Dryness [ ] Glaucoma
[ ] Cataracts [ ] Glasses [ ] Double Vision [ ] None
[ ] Other ____________________

Ears: [ ] Itching [ ] Vertigo [ ] Infections [ ] Earaches [ ] Discharge
[ ] Ringing [ ] Decrease Hearing [ ] None
[ ] Other ____________________

Nose: [ ] Recent Cold [ ] Stuffiness [ ] Bleeding [ ] Discharge
[ ] Sinus Infection [ ] None
[ ] Other ____________________

Mouth: [ ] Gum Bleed [ ] Sore Throats [ ] Hoarseness [ ] None
[ ] Other ____________________

Cardiac: [ ] Chest Pain [ ] Murmur
[ ] Irregular Heartbeats [ ] Dizziness
[ ] Swelling of legs [ ] Shortness of Breath ( ) activity
[ ] None ( ) rest
[ ] Other ____________________ ( ) night

Pulmonary: [ ] Cough [ ] Sputum [ ] Wheezing
[ ] Asthma [ ] Shortness of Breath [ ] None
[ ] Other ____________________

Gastrointestinal: [ ] Constipation [ ] Nausea [ ] Black Stool [ ] Diarrhea
[ ] Rectal Bleeding [ ] Vomiting [ ] None
[ ] Other: ____________________

Skin: [ ] Rashes [ ] Lumps [ ] Sore [ ] Nail change[ ] Dryness
[ ] Color change [ ] Hair loss [ ] Itching [ ] None
[ ] Other:____________________

Breast: [ ] Lumps [ ] Discharge [ ] Discomfort [ ] None
[ ] Other ____________________

Neurological: [ ] Vertigo [ ] Numbness [ ] Seizure [ ] Migraines [ ] Tingling
[ ] Black out spells [ ] Headaches [ ] Tremors [ ] Weakness [ ] None
[ ] Other ____________________

Psychiatric: [ ] Anxiety [ ] Memory Loss [ ] Depressed [ ] Libido less [ ] Tension
[ ] Nervousness [ ] None
[ ] Other ____________________

Urinary: [ ] Urgency [ ] Painful menses [ ] Frequent urination
[ ] Decrease Stream [ ] Blood in urine [ ] Incontinence [ ] None
[ ] Other ____

Blood: [ ] Bruising [ ] Gingival Bleeding [ ] Thin blood [ ] None
[ ] Other ____

Bone/Joint: [ ] Joint pain [ ] Backache [ ] Stiffness
[ ] Gout [ ] Swelling [ ] None
[ ] Other ____

Endocrine: [ ] Heat Tolerance [ ] Cold intolerance [ ] Frequent Hunger
[ ] High Blood sugar [ ] Sweating [ ] Thirst [ ] None
[ ] Other ____

Past Medical History

High Blood Pressure	Yes [ ]	No [ ]	Heart Murmur	Yes [ ]	No [ ]
Coronary Artery Disease	Yes [ ]	No [ ]	Emphysema	Yes [ ]	No [ ]
Asthma	Yes [ ]	No [ ]	Ulcer	Yes [ ]	No [ ]
Intestinal Problems	Yes [ ]	No [ ]	Kidney disease	Yes [ ]	No [ ]
Liver Disease	Yes [ ]	No [ ]	Diabetes	Yes [ ]	No [ ]
Seizures	Yes [ ]	No [ ]	Cancer	Yes [ ]	No [ ]
Stroke	Yes [ ]	No [ ]	Thyroid Disease	Yes [ ]	No [ ]

Other: ____

Past Surgical History:

1. ________________________________Month/Year:__________
2. ________________________________Month/Year:__________
3. ________________________________Month/Year:__________
4. ________________________________Month/Year:__________
5. ________________________________Month/Year:__________
6. ________________________________Month/Year:__________
7. ________________________________Month/Year:__________
8. ________________________________Month/Year:__________

Please mention any other symptoms or illnesses not previously documented:
____
____
____
____
____

Family History:

			Relationship Age Alive/Deceased
High Blood Pressure	Yes [ ]	No [ ]	______________________________
Heart Murmur	Yes [ ]	No [ ]	______________________________
Coronary Artery Disease	Yes [ ]	No [ ]	______________________________
Emphysema	Yes [ ]	No [ ]	______________________________
Asthma	Yes [ ]	No [ ]	______________________________
Ulcer	Yes [ ]	No [ ]	______________________________
Kidney disease	Yes [ ]	No [ ]	______________________________
Liver Disease	Yes [ ]	No [ ]	______________________________
Diabetes	Yes [ ]	No [ ]	______________________________
Seizures	Yes [ ]	No [ ]	______________________________
Cancer	Yes [ ]	No [ ]	______________________________
Stroke	Yes [ ]	No [ ]	______________________________
Thyroid Disease	Yes [ ]	No [ ]	______________________________
Other: ______________________________			______________________________

Social History:

Who lives with you now?

____

Who would be available to help you in the event of a major operation?

____

Education (circle): High School Tech School College Grad School

Employment (circle): Employed Student Disabled Retired Unemployed

Previous/Current employment: ____

Marital Status: Single Married Divorced Separated Widowed

Smoking history (circle): Never Smoked Smoke now Pack/day _______

Quit smoking (date) _____/_______

I have smoked ______ years

Alcohol history (circle): Never Drink Drink now How much /day _______

Quit drinking (date) _____/_______

Started Drinking at age ______

Cardiac Procedures:

	Month / Year	**Hospital/Clinic**
Cardiac Stress Test		
Chest CT Scan/MRI		
Echocardiogram		
Rt. Heart Catheterization		
Lt. Heart Catheterization		
Viability Study		

If patient has an HMO insurance plan, they MUST bring the referral letter with them to the appointment.

Name____

PRIMARY INSURANCE

Name of Insurance Company: ______________________________ Eligibility Date____________

Address: ____ Co-pay___________________________

Type of Policy: HMO POS EPO PPO

Policy # ________________ Group # ________________ Phone #___________________

Person Insured: _________________ Insured DOB: ___/____/_____ Relationship: ___________

SECONDARY INSURANCE

Name of Insurance Company: ______________________________ Eligibility Date____________

Type of Policy: HMO POS EPO PPO INDEM

Address: ____

Policy # ___________________ Group # ___________________ Phone #__________________

Person Insured: _________________ Insured DOB: ___/____/_____ Relationship____________

I hereby authorize Florida Advanced Cardiothoracic Surgery to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

____ ________________
Patient's Signature Date

Florida Advanced Cardiothoracic Surgery

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

RELEASE THE HEALTH RECORDS SPECIFIED BELOW:

Patient Name: ___________________________ Social Security #_________________

Date(s) of Service:

[X] All general medical records OR [ ] Limited records (specify):_________________________

THESE RECORDS ARE TO BE PROVIDED TO: *(please check box)*

[X] **Florida Advanced Cardiothoracic Institute, P.L. Phone: (813) 844-3228**
5 Tampa General Circle, Suite 820 Fax: (813) 844-7730
Tampa , Florida 33606

[ ] Health Plan or Health Care Provider *(Section B must be completed)*

Section B: Must be completed only if a health plan or a health care provider has requested the authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure? Medical Care
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? [ ] Yes [X] No
2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: ___________
   b. In understand that I may see and copy the information described on this form if I ask for it, and that I receive a copy of this form after I sign it. Initials: __________

AUTHORIZED BY: X____

(Date signed)_______________ (signature of patient or authorized representative*)

***Authorized Representatives** [ ] Parent [ ] Surviving Spouse [ ] Legal Guardian [ ] Administrator/Executor of Estate
[ ] Other (specify):___
if legal guardian, administrator or executor of estate, legal proof of this status must accompany this authorization,

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These records are copied and released to you as a courtesy on your first request. Additional requests for copies will be charged at $1.00 per page for the first 25 pages, then $0.25 per page thereafter.

PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the authorization of the person to whom such information pertains, or as otherwise permitted by law. With regard to HIV/AIDS, substance abuse, or psychiatric/psychological records, a specific, written authorization is required.

Notice of Privacy Practices

This is a Notice of Privacy Practices for:
Florida Advanced Cardiothoracic Surgery, LLC

Purpose: This Notice of Privacy Practices ("**Notice**") presents the information that federal law requires us to give our patients regarding our privacy practices.

Florida Advanced Cardiothoracic Surgery, LLC is required to provide you with this Notice pursuant to the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") ("**Privacy Rules**"). We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice and on our website. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR OBLIGATIONS

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal obligations, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2006, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you when you first receive services from us after the date the revised Notice becomes effective or upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for our treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use or disclose your health information to your health insurer to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. For example, we may use or disclose your health information in order to conduct an internal assessment of the quality of care we provide.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, to the extent necessary to help with your health care or with payment of your health care, if you agree that we may do so. We may also advise these persons of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with

common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disclosures Permitted or Required by Law: We are permitted and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

1. To public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse and other public health issues;
2. to health oversight agencies such a governmental auditors, the Florida Agency for Health Care Administration, the Florida Department of Health and other agencies when required;
3. to any individual when Florida Advanced Cardiothoracic Institute, P.L. is ordered by a court or other legal process to do so;
4. To law enforcement officials when necessary for law enforcement purposes and required by law;
5. to a coroner or medical examiner when necessary to enable them to perform their duties;
6. to organ procurement organizations, to enable them to make suitability determination;
7. In cases of emergency; or
8. To researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as a voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Your Authorization: Other uses and disclosures of your health information will be made if you give us written authorization to do so. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

PATIENT RIGHTS

You have certain rights regarding your health information. These rights include:

1. The right to obtain a paper copy of this Notice;
2. The right to inspect and copy your health information (copies are available for a reasonable fee);
3. The right to request amendments to your health information you believe to be inaccurate;
4. The right to obtain an accounting of Florida Advanced Cardiothoracic Surgery uses and disclosures of your health information, subject to certain exceptions;
5. The right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request); and
6. The right to request that communications regarding your health information be sent by alternative means or at alternative locations.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or wish to exercise any of your rights described herein, please contact using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Danielle McKinnon
Telephone: 813-844-3228
Facsimile: 813-844-7730