Baker-Gilmour Cardiovascular Institute

Patient Information

GENERAL PATIENT INFORMATION (All information is confidential)

FULL NAME: _____ DOB: _____ SEX: (CHECK ONE) ☐ MALE ☐ FEMALE

MARITAL STATUS: (CHECK ONE) ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED SSN: _____

ADDRESS: _____ CITY | STATE | ZIP _____

PHONE NUMBERS: HOME:_____ CELL:_____ WORK:_____

(IF YOU HAVE MORE THEN ONE PHONE NUMBER CAN YOU PROVIDE)

INSURANCE INFORMATION

PRIMARY INSURANCE: EFFECTIVE DATE: _____

☐ HMO ☐ MEDICARE ☐ MEDICAID ☐ PPO ☐ TRADITIONAL ☐ WC (SEE BELOW) OTHER

INSURANCE COMPANY NAME:_____

INSURED'S Name (other than patient):_____ DOB:_____

INSURED'S SSN(OTHER THAN PATIENT):_____

INSURED'S RELATIONSHIP TO PATIENT: (CHECK ONE) ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

POLICY OR CONTRACT NUMBER:_____ GROUP NUMBER:_____

SECONDARY INSURANCE: EFFECTIVE DATE: _____

☐ HMO ☐ MEDICARE ☐ MEDICAID ☐ PPO ☐ TRADITIONAL ☐ WC (SEE BELOW) OTHER

INSURANCE COMPANY NAME:_____

INSURED'S Name (other than patient):_____ DOB:_____

INSURED'S SSN(OTHER THAN PATIENT):_____

INSURED'S RELATIONSHIP TO PATIENT: (CHECK ONE) ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

POLICY OR CONTRACT NUMBER:_____ GROUP NUMBER:_____

REFERRING PHYSICIAN INFORMATION

PHYSICIAN'S NAME: _____ PHONE NUMBER: _____

WORKER'S COMP

DATE OF INJURY:_____ INSURANCE COMPANY:_____

CASE #:_____ CASE MANGER:_____ PHONE:_____

EMERGENCY CONTACT INFORMATION

WHOM SHOULD WE CALL IN CASE OF AN EMERGENCY (NAME:_____

PHONE:_____ RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ SIBILING ☐ FRIEND ☐ OTHER

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: ☐ YES ☐ NO

PATIENT'S SIGNATURE:_____ DATE:_____

Patient Medical History-Health Habits

Special Diet	☐ None	☐ Low Cholesterol	☐ Diabetic	☐ Low Salt
Tobacco	☐ Never	☐ Cigarettes (# per day) _____		☐ Quit
Alcohol	☐ None	☐ Rarely		☐ One or more drinks per day
Flu Shot	☐ Never	☐ Yearly		
Pneumonia Vaccine		☐ Never		☐ In past 7 years

Are you currently taking any narcotic substance, other than those prescribed by a licensed physician?

_____

Do you have a past history of substance abuse?

_____

Family History

Is there a family history of: Please check off

	Mother	Father	Brother	Sister
High Blood Pressure	☐	☐	☐	☐
Sugar Diabetes	☐	☐	☐	☐
Heart Attack or Stroke Age 50	☐	☐	☐	☐
Cholesterol Problems	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐

Illnesses

Has a doctor ever told you that you had any of the following? Circle the ones that the answer is yes

Heart Attack Diverticulosis Chronic Bronchitis Stroke Gout Hiatal Hernia Angina (Heart Pain)

Kidney Disease Enlarged Prostate High Blood Pressure Peptic Ulcer High Cholesterol Arthritis

Gallbladder Stones Sugar Diabetes Glaucoma Thyroid Disease (High or Low) Asthma

Cancer of any Kind

Past Surgical History

Check off any of the surgeries that you have had and list the date of the procedure.

☐ Coronary Artery Bypass Surgery _____ ☐ Pacemaker _____ ☐ Balloon Angioplasty_____

☐ Gallbladder Removed_____ ☐Carotid Artery Surgery (Neck)_____ ☐ Femoral Artery Surgery (Legs)_____

☐ Other

Medications

What medications do you presently take? (Include Eye Drops)

_____

_____

PLEASE COMPLETE INFORMATION ON BOTH SIDES

Review of Systems

Put a check in ether the YES or No column. During the PAST YEAR have you suffered any of the following problems? Please CIRCLE the complaint that prompted you to make this appointment.

	YES	NO
Racing or skipping heart	☐	☐
Pains or tightness in the chest, arms or jaw w/exercise	☐	☐
Pain or tightness in the chest, arms, or jaw w/ emotional upset	☐	☐
Difficulty breathing w/ exercise	☐	☐
Difficulty w/ breathing lying down	☐	☐
Swelling of feet or ankles that is not gone after night's sleep	☐	☐
Persistent cough or hoarseness	☐	☐
Significant weight loss or gain	☐	☐
Skin Lesion that won't heal	☐	☐
Pain in the legs with walking	☐	☐
Burning stomach pains on an empty stomach	☐	☐
Pain or difficulty swallowing	☐	☐
Faint feeling or passing out	☐	☐
Significant change in bowel habits	☐	☐
Recurrent weakness of an arm or leg	☐	☐

Allergies

Do you have any allergies to any medications? ☐ YES ☐ NO

If YES, list:

_____

_____

PLEASE COMPLETE INFORMATION ON BOTH SIDES

Baker-Gilmour Cardiovascular Institute

3550 University Blvd South, Suite 302
Jacksonville, FL 32216
P. 904.733.4444 F. 904.733.5377

300 Health Park Blvd, Suite 1006
St. Augustine, FL 32086
P. 904.794.7050 F. 904.794.7135

Release of Medical Information Request Form

Information Being Released to:	Information Being Released from:
Baker-Gilmour Cardiovascular Institute **(circle location)**	_____ _____

Information Requested | Information Disclosed:

Name of Patient:_____

DOB: _____ SSN:_____

Expiration Date of Authorization
This authorization is effective through____/_____/_____ unless revoked or terminated by the patient or the patient's person representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Baker-Gilmour Cardiovascular Institute to the attention of Medical Records

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it has been sent. The privacy of this information may not be protected under the federal privacy regulations.

The release of any information considered super-confidential under Florida Law, such as that regarding psychiatric, drug, or alcohol abuse, HIV/AIDS testing, counseling, or treatment or sensitive materials which may or may not be in my medical records is hereby
_____Authorized or _____Not Authorized

I further understand that Florida Statues (Rule 38F-7.601. Florida Administrative Code) allow health care providers to charge no more than $1.00 per page for the first 25 pages of written materials, 25 cents for each additional page and the actual cost of reproducing non-written reports such as x-rays, except in the case of Workers Compensation (where the charge is only 50 cents per page)

Printed Patient Name:_____

Signature of Patient:_____ Date:_____

Patient Representative Name (if patient is unable to sign)_____

Signature of Representative:_____ Relationship:_____

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Financial Policy

If you have a referral-based HMO/POS, it is your responsibility to make sure that you have a valid referral upon each visit, and that you pay your co-pay amount at check-in.

Self-Pay patients, please be prepared to pay in full at the time services are rendered unless prior arrangements have been made with the billing department.

I authorize the release of information and assignment of benefits to Drs. Baker & Gilmour.

_____ _____

Patient's Signature Date

_____ _____

Please Print Name DOB

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ASSIGNMENT OF BENEFITS

I authorize my insurance carrier to release information regarding my coverage to **Baker and Gilmour, M.D., P.A.** I also authorize agents of any hospital, treatment center or previous physicians to furnish copies of any records of my medical history, service or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within **Baker and Gilmour, M.D. P.A.**

I authorize all payment to **Baker and Gilmour M.D. P.A.** for physical services, tests and procedures. This assignment covers any and all benefits under Medicare; other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept the Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to **Baker and Gilmour, M.D.P.A.**

I have read and received a copy of the above statement and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____

Patient's Signature Date

_____ _____

Please Print Name DOB

_____ _____

Responsible Party Signature Relationship

_____ _____

Please Print Name Date

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HIPAA 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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

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 that are involved in your care treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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 a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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.

Healthcare 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 that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as required by law; Communicable Disease Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at anytime, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: 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 protected health information that is subject to law that prohibits access to protected health information.

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 healthcare 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 who you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this notice of our privacy practices:

Print Name:_____ Signature:_____ Date:_____

BAKER-GILMOUR CARDIOVASCULAR INSTITUTE
HIPAA AUTHORIZATION

I _____ DOB:_____ authorize
Patient's Name

Baker-Gilmour Cardiovascular Institute to disclose and allow the following people to have access to ALL of my personal and confidential medical information including by phone, to pick up records for me, and financial information.

Name of Person	DOB	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand:

- This is a full release of all my medical information-**including mental health, drug, alcohol, HIV/AIDS and other sexually transmitted disease information**
- **I do not have to sign this form.** My refusal will not change my ability to get treatment, payment for treatment or benefits.
- Once information is shared as allowed by this Authorization, it may not be protected by law. Someone may be able to share my information with others without my permission.
- This Authorization is effective until (1 year from today):_____
- I can cancel this Authorization at any time. If I want to cancel it, I will send written notice to my doctor's office. I cannot cancel this Authorization as to information that has already been shared.
- Baker-Gilmour cannot use my medical information without my permission, except in the ways described in Baker-Gilmour's Notice of Privacy Practices.
- Upon my request, I have been given a copy of this form.

I have read this form or had it read to me. I understand it. I have had a chance to ask questions, and my questions were answered to my satisfaction. I sign this form voluntarily.

_____ _____

Patient's Signature Date Witness Signature Date