TAMPA CARDIAC SPECIALISTS

Patient Information

Name (Last, First, MI)		Email address	
Street Address	City	State	Zip
Home Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	
SSN	Date of Birth	Gender ☐ Male ☐ Female	
Employer ☐ Retired ☐ Disabled ☐ Unemployed		**Marital Status** ☐ Single ☐Married ☐ Divorced ☐ Widowed ☐ Separated	
Race ☐ Prefer not to Disclose ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other		**Ethnicity** ☐ Hispanic or Latino ☐ Non Hispanic or Latino	**Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Emergency Contact

Name	**Relationship to Patient**	
Home Phone ( ) Preferred ☐	**Work Phone** ( ) Preferred ☐	**Cell Phone** ( ) Preferred ☐

Referral Info

Referring Physician's Name	**Physician Phone/Fax (if known)** ( )
Physician Address	

PCP Info

Primary Care Physician's Name (☐ Check if same as Referring Physician above)	**Physician Phone/Fax (if known)** ( )
Physician Address	

Pharmacy Info

Primary Pharmacy	**Cross Streets (If known)**	**Phone** ( )
Mail Order Pharmacy	**Phone** ( )	**Fax** ( )

Insurance Information

Primary Insurance Company	**Policy #**	**Group #**	
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	**Name of Subscriber (if other than patient)**		
Subscriber's Social Security #	**Date of Birth**	**Employer of Subscriber**	**Work Phone** ( )
Secondary Insurance Company	**Policy #**	**Group #**	
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	**Name of Subscriber (if other than patient)**		
Subscriber's Social Security #	**Date of Birth**	**Employer of Subscriber**	**Work Phone** ( )

Authorization to Pay Benefits to Tampa Cardiac Specialists

I hereby authorize payment directly to the Physician for medical benefits. I understand that I am responsible to pay for non-covered services, co-payments, and deductibles including any other balances for which I am obligated under my insurance plan.

Patient Signature:_____ **Date:** ____/____/____

Authorization to Release Information

I hereby authorize Tampa Cardiac Specialists to release any medical or billing information acquired in the course of my treatment to my insurance company/plan or to my primary and/or referring physician.

Patient Signature:_____ **Date:** ____/____/____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Kevin J. Makati, M.D., PL and Christopher J. Pastore, M.D., PL, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third party payer can verify that services billed were actually provided
And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have a right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

Notification of Family Members:
Please share information with: _____

_____

I request the following restrictions to the use or disclosure of my health information:

_____

_____

Signature of Patient or Legal Representative _____

Date: _____/_____/_____

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PATIENT MEDICATION VERIFICATION FORM

PATIENT NAME: _____ **DATE OF BIRTH**: _____

ALLERGIES: _____

_____

Medication Name	Dose/Strength	Frequency	Prescribing Physician

TAMPA CARDIAC SPECIALISTS

FINANCIAL POLICY

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes in your address, telephone numbers or insurance policy so that your coverage can be re-verified prior to your appointment.

- **HMO policy: If your insurance policy requires a referral from your primary care physician, it is your responsibility to obtain that referral faxed to our office prior to your appointment.**

- Be prepared to pay your copay at each visit. Payment may be made by cash, check, Visa, MasterCard, Discover or American Express. If you do not pay your copay, your visit to the physician may be rescheduled.

- **Not all services are a covered benefit with all insurance plans.** You are responsible for any non-covered charges not payable by your insurance policy. For medical care not covered by your insurance, payment in full is due at the time of service.

- Any patient balance remaining from previous services is expected to be paid *prior* to any additional services. Any need for extended payments must be discussed in advance with our business office.

- **For patients requiring a payment plan**: automatic electronic drafts are available. You will need to complete an authorization form and the payment for your services will be drafted from your checking account. Please inquire about establishing an electronic draft program with our front desk.

- **After two month of non-payment**: a $25.00 handling fee will be added to your bill, every month, until it is paid in full. This handling fee will cover the labor, stationery, and postage required to continue to send out statements to patients who have not paid their bill.

- **Insufficient Funds Policy**: In the event that your check / electronic draft return due to insufficient funds, we will request the full payment plus a service fee of $35.00.

- **IF YOU HAVE A BALANCE DUE ON YOUR ACCOUNT AT THE TIME OF THE VISIT:**
  - **Balances of $120 or less** are due in full at the time of check in
  - **Balances greater than $120**: $120 is due at check in and you may be eligible to set up a payment plan for the remainder of your balance.

IF YOU FAIL TO ADHERE TO THE TERMS OF YOUR PAYMENT PLAN, YOUR ACCOUNT WILL BE SENT TO COLLECTIONS

Our practice firmly believes that a good physician patient relationship is based upon understanding and good communication. Questions about financial arrangements should be made to 813-229-9292. If you have any questions about the above information, *please* do not hesitate to ask us. We are here to help you.

Please sign that you have read and agree with the financial policy of Tampa Cardiac Specialists, LLC.

Patient Signature Date

Print Name Date of Birth

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SPECIALISTS

Recording Acknowledgement

Acknowledgement of Prohibition of Recording of Office Visit

In keeping with Florida Law requiring the consent of both parties, I hereby acknowledge that the recording or reproduction of any part of my office visits by any form of media, including but not limited to video or audio recording, without the expressed written consent of Tampa Cardiac Specialists, LLC, is strictly prohibited.

Patient Signature Date

Print Name Date of Birth