NEW / RETURNING PATIENT INFORMATION

1.1

WELCOME TO OUR OFFICE ***DATE*** _____

This form has been revised according to our data requirements.* ***Please complete all fields**. If not applicable, note N/A.*

PATIENT NAME: (PLEASE PRINT) _____ _____ **LAST** **SUFFIX** _____ _____ **FIRST** **M.I.**	**SS#:** _____–_____–_____ **DOB:** _____/_____/_____ **PREFERRED LANGUAGE:**_____ **EMAIL ADDRESS:**_____	**MARITAL STATUS:** **S___ M___ W___ D___ SEP___** **GENDER: M___ F___** **ETHNICITY**: _____
PHYSICAL ADDRESS: **(street)** _____ **(city, state, zip)** _____ ***MUST PROVIDE 9 DIGIT ZIP CODE**	**HOME PHONE:** ( ) _____–_____ **CELL PHONE:** ( ) _____–_____	**EMERGENCY CONTACT NAME/RELATION:** _____ ( ) _____–_____ **EMERGENCY PHONE**
MAILING ADDRESS (if different than above): **(PO box, or street)**_____ **(city, state, zip)** _____ ***MUST PROVIDE 9 DIGIT ZIP CODE**	**OCCUPATION (indicate if student):** _____ **EMPLOYED HOW LONG?** _____	_____ **EMPLOYER** ( ) _____-_____ **EMPLOYER PHONE**
SPOUSE (or parent) **NAME**:	**SS#**: _____–_____–_____ **DOB**: _____/_____/_____	_____ **EMPLOYER** ( ) _____–_____ **EMPLOYER PHONE**

JEHOVAH WITNESS ____ Yes ____No (pertaining to the acceptance/denial of blood transfusion/products)
CONSENT: _____Yes _____No to receive medication history electronically from your pharmacy*–must answer Y or N*
PHARMACY: _____ PHARMACY PHONE: _____

REFERRING PHYSICIAN:	FAMILY/PRIMARY PHYSICIAN:	CARDIOLOGIST:

PRIMARY INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER	INSURED'S NAME/RELATION
2NDARY INSURANCE CARRIER	**POLICY NUMBER**	**GROUP NUMBER**	**INSURED'S NAME/RELATION**

HOW DID YOU HEAR ABOUT US? ☐ newspaper ☐ magazine ☐ physician ☐ family member ☐ friend ☐ other _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR INSURANCE/BILLING OFFICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder (**please print**) _____

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to **Atlantic Cardiovascular & Thoracic Surgeons, LLC** for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) **I have received Atlantic Cardiovascular & Thoracic Surgeons, LLC's Notice of Privacy Practices**.

Signature _____ **Date**_____

Atlantic Cardiovascular & Thoracic Surgeons, LLC
Our 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.

Our pledge regarding your health information:

We understand that medical information about you and your health is personal. We create a record of the care and services you receive from us. We need this record to provide you with quality care, obtain payment for the services we provide and to comply with legal requirements. This Notice applies to all of the records of your care generated by us, whether made by your personal doctor, other Practice doctors or Practice staff. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this Notice of our legal duties and privacy practices; and (3) follow the terms of the Notice that is currently in effect. The professional and non-professional staff at our Practice site(s) will follow the terms of the Notice.

How we may use and disclose medical information about you:

The following categories and examples describe the different way that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Category:	**Description and Examples:**
Treatment	We may share medical information about you with another physician, a hospital or other health care provider involved in your care. For example, a hospital may need to see a part of your medical record before you have surgery.
For payment	We may share medical information with Medicare or other health plans to obtain payment for services provided to you, to verify insurance coverage or to obtain authorization for further treatment. For example, an insurance company may need to see a part of your medical record, including any photographs* of your injury, wound, disease, etc., that they may request us to provide, before they will authorize or pay for the services.
For Practice operations	We may share medical information as necessary to manage the medical, legal and financial affairs of the Practice and to monitor the quality of services provided to our patients. For example, our attorney or accountant may need patient information in order to provide legal and financial services to the Practice. Any Business Associate with whom we share medical information will agree in writing to protect your privacy. In the event of your Protected Health Information being breached, as defined and amended by the Health Information and Technology for Economic and Clinical Health Act of 2009 (HITECH Act), whether done inadvertently or maliciously, you will be notified within 60-days of the Practice's acknowledgment of the breach. Although identity theft is very prevalent in today's electronic society, we have security measures in place, as well as the encryption of your Computerized Health Record, in order to prevent breach of your Protected Health Information.
Appointment reminders	We may disclose medical information to remind you of an appointment. We will disclose only the date, time and location of the appointment.
Family members and friends	We will share medical information to a friend or family member that is involved in your care or payment of your bill. We will give you an opportunity to agree or object to these disclosures unless it is clear from the circumstances that you do not object.
To meet legal requirements and for public health activities	We may disclose medical information to a government agency that oversees medical practice in the State such as the Florida Agency for Health Care Administration or the Board of Medicine. We are also required to report certain diseases and conditions to the local unit of the Department of Health for its public health activities.
Law enforcement, lawsuits, disputes and reports of abuse or neglect	We may disclose medical information to an attorney or law enforcement official to comply with a court order, subpoena, discovery request or other legal mandate. We may also disclose medical information to assist law enforcement with investigating a crime. For example, we are required to report wounds resulting from violence and incidents of abuse or neglect.
To avert a serious threat to health or safety	We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or that of the public or another person. Any disclosure, however, would only be to someone able to respond to the threat.

Category:	Description and Examples:
For special government functions	We may be required to disclose medical information to a government agency for national security purposes or a correctional facility in which you may be incarcerated, or to a military authority if you are in the service or a veteran.
Medical Examiners and Funeral Directors	We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about individuals to funeral directors as necessary to carry out their duties.

Other uses of medical information:

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your rights regarding medical information:

You may access your medical information	To access your medical information, you must submit your request to us at our address listed below. If you request copies, we may charge a fee allowed by law. We may deny your request in certain very limited circumstances. For example, we might deny access to psychotherapy notes that may be a part of your record.
You may amend or correct your medical information	You may ask us to amend or correct your medical information. Please make your request in writing and submit it to our office address listed below. You must provide a reason that supports your request.
You may request an "accounting of disclosures"	You may request a list of the disclosures we made of medical information about you, other than for treatment, payment or Practice operations as described above, and without your written authorization.
You may request restrictions on the use or disclosure of your medical information	You may request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or Practice operations. For example, you could ask that we not share information with a family member or friend about surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You may also request that your health information not be submitted to your health insurance carrier if you intend to pay for your services in full at the time of your treatment.
You may request confidential communications	You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will try to accommodate all reasonable requests.
You may have a paper copy of this Notice	You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of this Notice at any time, even if you obtained a copy electronically.

Changes to this Notice:

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in prominent locations at our Practice sites. The Notice will contain the effective date.

Exercise of privacy rights and complaints:

To exercise your privacy rights or to file a complaint, contact us at our address below. A complaint may also be filed with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Atlantic Cardiovascular & Thoracic Surgeons, LLC
Privacy Officer
588 Sterthaus Ave.
Ormond Beach, FL 32174
(386)672-9503, fax (386)672-0386

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Effective Date: April 14, 2003