ORLANDO HEART & VASCULAR INSTITUTE

407-767-8554
Fax 407-767-9121

CARDIAC DIVISION

Kishore Ranadive
M.D., F.A.C.C., F.S.C.A.I

Barry Weinstock
M.D., F.A.C.C., F.S.C.A.I

Udit Joshi
M.D., F.A.C.C.

INTERNAL MEDICINE DIVISION

Christina Gillmore
APRN-C
Board Certified Adult Medicine

Altamonte Springs
450 W. Central Pkwy.
Altamonte Springs, FL 32714

Apopka
33 S. Washington Ave.
Apopka, FL 32703

Name:_____ **Date:**_____ **Marital Status:** _____
SSN#: ___-___- ____ **Home Phone:** _____ **Birth Date:**_____
Sex:_____
Race: American Indian or Alaska Native/Black or African American/Asian/White/Native Hawaiian or Other Pacific Islander//Unknown/Decline **Ethnic Group:** Hispanic or Latino/Not Hispanic or Latino/Decline
Home Address:_____

City:_____ **State:** _____ **Zip Code:**_____

Employer: _____ **Occupation:** _____
Email Address: _____

***Patient Acknowledgement*:** I understand I have the right to accept and refuse medical treatment and to exercise my right and implement an "Advanced Directive," refers to any legal document that informs family members and medical personal how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

- ☐ I Have Not executed an Advanced Directive
- ☐ I Have executed an Advance Directive
  - ☐ Living Will Location of Form: _____
  - ☐ Durable Power of Attorney
  - ☐ Do Not Resuscitate (DNR) Order
  - ☐ Designation of health care surrogate form Designee/Guardian: _____

Signature: _____ **Witness:** _____ **Date:**_____

Insurance Assignment & Release Form: I hereby authorize my Insurance Benefits to be paid directly to ***Orlando Heart and Vascular Institute*** I also authorize the physician to release any information required and/or requested by insurance carrier**. *Office policy*: I understand that I am responsible for insurance deductibles, co-pays and co-insurances as per my insurance policy. I understand all fees are due at the time services are rendered**. I understand that here is a **$45** dollar charge on all returned checks and a **$50** dollar charge for appointments cancelled without **24** hours prior notice or failure to show up for a scheduled appointment. I also understand that ***Orlando Heart and Vascular Institute*** files claims to the insurance company as a courtesy, and that I am responsible for any service the insurance company does not pay for.

Signature: _____ **Date:**_____

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ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

With my consent, Orlando Heart and Vascular Institute may call home or designated location and leave a message on voice mail, answering machine in reference to any items that assist the practice in carrying out TPO (treatment, payment, and healthcare operations) such as appointment reminders, insurance items and calls pertaining to my medical care, including laboratory results, etc.

Name:_____ **DOB:**_____

Signature: _____

Date:_____

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Medical Records Release

Date:_____

Patient Name:_____

DOB:_____ **SSN#:** _____ **Phone:**_____

Patient Address:_____

City:_____ **State:**_____ **Zip Code:**_____

I hereby authorize _____to release medical information to:
Name: **Orlando Heart and Vascular Institute**
Address: **450 W. central pkwy**
Altamonte Springs, FL 32714
Phone: **407-767-8554** Fax: **407-767-9121**

SPECIFIC DOCUMENTS TO BE RELEASED:
( ) ALL Records ( ) Discharge Summary
( ) History/Physical ( ) Procedure Report(s) ( ) Consultation
( ) Labs ( ) Radiology Reports ( ) Progress Notes
( ) HIV/AIDS ( ) Other: _____
( ) Specified Date(s) of service _____
( ) Hand Carry ( ) Mail ( ) Fax

PURPOSE FOR INFORMATION:
( ) Continued Medical Care ( ) Insurance ( ) Personal ( ) Transfer of care

This request is authorized to include any federal and/or state protection under Florida Statutes 394.459(9) Psychiatric Information, 397.053/396.112 Drug and Alcohol Abuse Information, 381.609 HIV and AIDS related conditions and/or 397.50(3) records of minor client.

NOTICE TO REQUESTING PARTY: Florida statue has established guidelines and cost rates for the copying of records. Your signature on this form indicates your knowledge of this statement.

I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentially rules.

I hereby release ***Orlando Heart and Vascular Institute along with its Internal Medicine Division*** and their employees, agents, officer, and affiliates, from any and all liability, responsibility, claim and damages, which may result in the release of information authorized by the consent for release of information.

Sign: _____ **Date:**_____

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(If not patient, state relationship)

Form of ID verified _____

450 W. central pkwy Altamonte springs, FL 32714
Phone: (407) 767-8554 Fax: (407) 767-9121

Medication History Consent

Date:_____

I_____hereby give ***Orlando Heart and Vascular Institute and its Internal Medicine Division*** consent to access my medication history through Rx Hub.

Patient Signature: _____

DOB:_____]

Witness: _____ **Date:** _____

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Patient Demographics Information

Patient Name_____ **Date:**_____ **Phone:**_____
Address:_____

City: _____ State: _____ Zip:_____

D.O.B:_____ Sex:_____ **Marital Status:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** (____) ____-_____

Primary Care Physician: _____ **Phone:** (____) ____-_____
Insurance Name: _____ **Policy ID#:**_____ **Group#:**_____
Policy Holder: _____ **Relationship to Policy Holder:** _____
Insurance Phone #:_____

Patient Release Form

Medicare Benefits to Provider, Physicians and Patient:

I certify that the information given by me in applying for payment under File XVII of the Social Security Act is correct. I authorize any holder of medical information or other information about me to release the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign benefits payable for physician serviced to the physician or organization furnishing the services and authorize such physicians of organization to submit a claim to Medicare for payment.

Authorization for Medical and Diagnostic Treatment

I, the undersigned as a patient or his/her authorized representative, hereby authorized Orlando Heart and Vascular Institute ,LLC and/or its representative(s), to treat the condition(s) which appear indicated by the admission complaints and findings. I will be informed of the modes of treatment, risks involved, and the nature of the procedure(s) to be done. No guarantee has been made that my present condition will be cured.

Release of Medical Records

Release of medical records and medical information, the undersigned, as the patient or his/her authorized representative, hereby authorize Orlando Heart and Vascular Institute, LLC, and/or its representative(s) to release to my insurance company(s) or other appropriate agency(s) that information which is necessary to validate this claim. There will be a $1.00 per page for all copies of medical records.

Assignment of Insurance and Financial Responsibility

Assignment of insurance and financial responsibility; I hereby authorize payment to Orlando Heart and Vascular Institute ,LLC, for benefits otherwise payable by me, including major medical insurance. I understand that I am financially responsible for all charges incurred during this treatment program, whether or not paid by said insurance**. It is my responsibility to pay any deductible, copay or co-insurance amount or any other balance at the time of service**.

I Agree

I agree to pay Orlando Heart and Vascular Institute, LLC, any fees owed if referral form authorizing visit or testing is not brought in at time of visit or within ten days after the visit. I will be charged $35 for any form that requires Orlando Heart and Vascular Institute, LLC, to complete. I will be charged $50 for appointments not canceled 24 hrs in advance.

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The Undersigned

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or his/her authorized representative, to release Orlando Heart and Vascular Institute, LLC, or its employees from any liability which may arise from this action, whether or not foreseen at present.

Receipt of Notice of Privacy Practice

I, _____, have received a copy of Orlando Heart and Vascular, LLC, notice of privacy policy practices.

I authorize the release of my medical records to the following person(s) named below.

_____

_____

_____
Signature of Patient or Legal Representative

Date: ____ / _____ /_____

PATIENT MEDICAL HISTORY

Current Medications	Dose	Frequency					
		AM	PM	2x/day	3x/day	4x/day	As needed

Allergies

Have you ever had a reaction to any of the following: Latex ___Yes ___No
Iodine ___Yes ___No
IV Contrast___Yes ___No

Other Allergies:

Medicine/Substance_____ **Reaction** _____

Medicine/Substance_____ **Reaction** _____

Medicine/Substance_____ **Reaction** _____

Medicine/Substance_____ **Reaction** _____

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Hospital Preference _____

Pharmacy Preference _____ **Address**_____ **Phone #**_____

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Family History

Check All That Apply

	Alive	Age deceased	Diabetes	Heart Disease	Stroke	High BP	Early Heart Attack	Cancer (type)	Other
Mother									
Father									
Sisters									
Brother									
Maternal Grandmother									
Paternal Grandmother									
Maternal Grandfather									
Paternal Grandfather									
Children									

Social History

Tobacco	
	Use
☐ Never	Age started _____
☐ Quit	Year quit _____
☐ Current	#per day_____

Alcohol		Drinks per		
		Day	Week	Month
☐ Never	☐ Liquor			
☐ Quit	☐ Beer			
☐ Current	☐ Wine			

Recreational Drugs
☐ Never
☐ Quit
☐ Current

Cardiac Surgical History

- ☐ Vascular Angioplasty
- ☐ Cardiovascular Stent(s)
- ☐ Carotid Artery Surgery
- ☐ Pacemaker AICD Implant
- ☐ Carotid Artery Stent
- ☐ Coronary Artery Surgery
- ☐ Coronary Artery Stent
- ☐ Heart Bypass (CABG)
- ☐ Carotid Artery Angioplasty
- ☐ Peripheral Vascular Surgery
- ☐ Vascular Surgery Bypass

Non- Cardiac Surgical History

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Breast Surgery
- ☐ Carpal Tunnel Release
- ☐ C-Section
- ☐ Cholecystectomy (gallbladder)
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ Eye Surgery (cataract/lasik, etc.
- ☐ Gastric Bypass/Sleeve/Balloon
- ☐ Hysterectomy (uterus removed)
- ☐ Joint Replacement type _____
- ☐ Joint Surgery type _____
- ☐ Neck Surgery
- ☐ Prostate Surgery
- ☐ Small Intestine Surgery
- ☐ Spinal Stimulator
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy

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Previous Major Hospitalizations / Extended Hospitalizations > 3 Days

Reason for hospitalization _____ Year _____
Reason for hospitalization _____ Year _____
Reason for hospitalization _____ Year _____
Reason for hospitalization _____ Year _____
Reason for hospitalization _____ Year _____

Past Medical History

☐ Angina	☐ Dizziness/Vertigo	☐ Obesity
☐ Anxiety	☐ Drug/Alcohol Use or Abuse	☐ Osteoarthritis
☐ Arrythmia	☐ Gallstone/Gallbladder Disease	☐ Osteopenia
☐ Arthritis	☐ GERD/Heartburn	☐ Osteoporosis
☐ Asthma	☐ Headaches/Migraines	☐ Palpitations
☐ Bipolar Disorder	☐ Heart Attack	☐ Parkinson's Disease
☐ Bleeding Disorder	☐ High Cholesterol	☐ Sciatica
☐ Blood Transfusion History	☐ HIV/AIDS	☐ Seizures
☐ Cancer Type _____	☐ Hypertension	☐ SLE (Lupus)
	☐ Inflammatory Bowel Disease/ Crohn's, IBS, Celiac Disease	☐ Sleep Apnea
☐ Cardiomyopathy		☐ Spinal Stenosis
☐ Chest Pain	☐ Kidney Disease	☐ Stroke
☐ C.O.P.D.	☐ Leg Pains at rest ___ while walking ___	☐ Swelling of extremities ___ Edema of Feet/legs ___ Edema of Hand/fingers
☐ Coronary Artery Disease		
☐ Dementia	☐ Liver Disease	
☐ Depression	☐ Mental Health Condition _____	☐ Syncope/Fainting
☐ Diabetes Type I _____Type II _____		☐ Thyroid Disease
	☐ Murmur	☐

Immunizations

Have you had the COVID-19 series? No ____ (2 shots) ____ (3 shots) _____ (4 shots) _____
Have you had a FLU SHOT in the Last 12 months? Yes ____ No ____
Have you had a PNEUMONIA shot? Type (if known) _____ Year _____
When was your last TETNUS? Year (if known)_____ <5 years ____ <10 years _____ >10 years ____
Have you ever had the SHINGLES Vaccine? Yes ____ No ____ Year (if known) _____

Females (those born female) Only

Pregnancies

Age of onset menses (if known) _____	Never been pregnant _____
Last menses (month/year, if known) _____	Number of full term pregnancies _____
Last menses (month/year, if known) _____	Number of C-Sections _____
	During any pregnancy, did you have …. High Blood Pressure ____, Diabetes ___, Pre-Eclampsia ___, Eclampsia ___

Specialist Currently Seeing

Pulmonologist_____Endocrinologist _____Orthopedist _____

Nephrologist _____Rheumatologist_____Gastroenterologist _____

Hematologist/Oncologist _____ Other _____

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Online Communications Informed Consent

Instructions for Using Online Communications

You agree to take steps to keep your online communications to and from me confidential including:

- Do not store messages on your employer-provided computer; otherwise, personal information could be accessible or owned by your employer.
- Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private.
- Do not allow other individuals or other third parties access to the computer(s) upon which you store medical communications.
- Do not use email for medical communications. Standard e-mail lacks security and privacy features and may expose medical communications to employers or other unintended third parties.
- Withdrawal of this Informed Consent must be done by written online communications or in writing to my office.

Charges for Using Online Communications

Orlando Heart and Vascular Institute, LLC may charge for certain online communications. You will be informed in advance when/if these charges apply and you will be responsible for payment of these charges if you accept and use any fee-based service. You may choose to contact your insurance carrier to determine if they cover online communications.

Conditions of Using Online Communications

The following agreements and procedures relate to online communications:

- Orlando Heart and Vascular Institute, LLC will keep a copy of all medically important online communications in your medical record.
- You should print or store (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you.
- Orlando Heart and Vascular Institute, LLC will not forward online communications with you to third parties except as authorized or required by law.
- Online communications will be used only for limited purposes. Online communications cannot be used for emergencies or time-sensitive matters. It should be used with caution. If there is other information that you do not want transmitted via online communications, please notify our office. Orlando Heart And Vascular Institute, LLC cannot be held responsible.

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Please note that online communications **should never be used for emergency communications or urgent requests**. These should occur via telephone or using existing emergency communications tools.

- Orlando Heart and vascular Institute, LLC is not liable for improper disclosure of confidential information.
- Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an unanswered online communication was not received.
- You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. Orlando Heart and Vascular Institute, LLC is not responsible for breaches of confidentiality caused by you or an independent third party.
- Orlando Heart and Vascular Institute, LLC will not engage in any illegal online communications, including illegally practicing medicine across state lines.

Access to Online Communications

The following pertains to access to and use of online communications:

- Online communications does not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. .
- Orlando Heart and Vascular Institute, LLC may stop providing online communications with you or change the services I provide online at any time without prior notification to you.

Risks of Using Online Communications

All medical communications carry some level of risk. While the likelihood of risks associated with the use of online communications, particularly in a secure environment, is substantially reduced, the risks are nonetheless real and very important to understand. It is very important that you consider these risks each time you plan to communicate with Orlando Heart and Vascular Institute, LLC, and communicate in such a fashion as to mitigate the potential for any of these risks.

These risks include, but are not limited to:

- Online communications may travel much further than you planned. It is easier for online communications to be forwarded, intercepted, or even changed without your knowledge.
- Online communication is easier to falsify than handwritten or signed hard copies. A dishonest person could attempt to impersonate you to try to get your medical records.
- It is harder to get rid of an online communication. Backup copies may exist on a computer or in cyberspace, even after you have deleted your copies.
- Online communication is not private simply because it relates to your own medical information. Use a secure network to avoid using standard e-mail or e-mail systems provided by employers. Employers and online services have a right to inspect and keep online communications transmitted through their system.
- Online communications are also admissible as evidence in court.
- Online communications may disrupt or damage your computer if a computer virus is attached.

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Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered and I understand and concur with the information provided in the answers.

You will find our Orlando Heart and Vascular Institute website at www.heartorlando.com

Email: _____

Patient Signature: _____

Date: _____

Witness: _____