6710 Old Wolf Bay Road
Palatka, FL 32177

PUTNAM
HEART CENTER

Tel (386) 326-1590
Fax (386) 326-1592

and Cardiac Catheterization Laboratory

Mukesh Goel, M.D.
A. Thomas Romero, M.D.

PATIENT DEMOGRAPHICS FORM

(PLEASE PRINT)

Name:_____ Date:_____

SS #_____ Date of Birth:_____

Mailing Address:_____

City:_____ Zip:_____

Home Phone:_____ Cell:_____

E-Mail Address:_____

Primary Care Physician:_____

Insurance:_____ Policy#_____

Name of Pharmacy:_____

Emergency Contact:

Last Name:_____ First Name:_____

Phone #_____ Alternate #_____

Relation to patient:_____

HIPPA REQUIRES THAT YOU LIST WHO YOU WOULD LIKE TO HAVE ACCESS TO YOUR MEDICAL INFORMATION, IF THEY ARE NOT LISTED WE BY LAW CAN NOT GIVE ANT INFORMATION ABOUT YOU.

1._____

2._____

3._____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
RELEASE OF RECORDS

PATIENT NAME:_____ **D.O.B:**_____ **SS#**_____

I HEARBY AUTHORIZE:

Putnam Heart Center
6710 Old Wolf Bay Rd
Palatka, Fl 32177
Phone: (386) 326 - 1590
Fax: (386) 326 - 1592

TO RELEASE THE FOLLOWING MEDICAL INFORMATION OR REQUEST MEDICAL INFORMATION REGARDING THE ABOVE NAMED INDIVIDUAL FOR THE PURPOSE OF CONTINUITY OF CARE AND/ OR SURGICAL CLEARANCE.

Type of information:

_____Entire record
_____History and Physical
_____Labs
_____Hospital records
_____Radiology and other imaging studies
_____Procedure reports
_____consults
_____Other:_____

I understand that the infomration in my health record may include information relating to sexuaqlly transmitted diseases, Acquired Immunodeficiency SyndromE (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand the following: See CFR 164.508 (c)(2)(i-iii):

* I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

* The information released in response to this authorization may be re-disclosed to other parties.

* My treatment or payment for my treatment cannot be conditional upon the signing of this authorization.

* Any facsimile, copy, or photocopy of the authorization shall serve, to release the records requested herein.

This authorization shall be in force and effective from date of execution until such time as I revoke in writing the permission granted by this document.

I have read and understood this infromation and am the patient or am authorized to act on behalf of the patient to sign this document.

Patient Signature_____ Date:_____

Witnes Signature_____ Date:_____

BILLING INFORMATION

Payment is required at time of service uless prior arrangements have been made.

For your convenience, we will bill your insurance company for charges incurred by you. IN order to provide this service for you we must have complete billing information. If a claim form is required by you insurance, it is your repsonsibility to provide us with that form. We ask that complete your portion of the form. If your insurance company requires additional forms to be completed by our staff, there is a 10.00 fee. (example: disability formse, insurance forms, out of work forms, etc.) In addition , if you have a secondary insurance and you provide us with the information, we will gladly forward a claim to the insurance company.

ANY PORTION OF THE CHARGES NOT COVERED BY YOUR INSURANCE COMPANY BECOMES THE PATIENT RESPONSIBILITY.

After 60 days if we have not heard antying from the insurance company, we will transfer these charges to your account and they will become soley your responsibility. We will not refile these charges to the your account. We will however be happy to print the claims for you so that you may be reimbursed after you have settled your account with us.

If your insurance company feels any of our charges to be over what is consdiered REASONABLE AND CUSTOMARY, you are responsible for any amount that your insurance deems your responsiblity. IT IS YOUR RESPONSIBILITY TO SEE THAT YOUR INSURANCE COMPANY PAYS YOUR CLAIMS.

I, _____ UNDERSTAND AND AGREE TO THESE TERMS.

_____ **Date:** _____

Patient Signature

Putnam Heart Center
CONSENT TO BILL

I _____, consent to the use or disclosure of my "protected health information" as defined in the **Health Insurance Portability and Accountability Act of 1996 (HIPPA)** This consent is for the sole purpose of obtaining payment for my health care as provided by **Putnam Heart Center and Affiliated Care Givers** for services provided by Putnam Heart Center health care providers .

My "protected health information" means health information including but not limited to, my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house for the purposes of obtaining payment for services rendered by Putnam Heart Center and its affiliates.

I further understand that I have the right to revoke this consent in writing at any time except to the extent that Putnam Heart Center has taken previous action in reliance on this consent.

_____ Date_____
Signature or Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Putnam Heart Center

Notice of Privacy

(THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIONN. PLEASE REVIEW IT CAAREFULLY.)

Introduction

At Putnam Heart Center, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Putnam Heart Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Putnam Heart Center, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain and accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Putnam Heart Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem:

If you have any questions and would like additional information, you may contact the practice's Privacy Officer, Susan Drago at (386) 326-1590.

Disclosure of your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information however, we require the business associates to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, or other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Signature of Reviewer

Date