



CARDIOVASCULAR CARE, P.A.

ANNUAL PATIENT INFORMATION UPDATE

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Please review and update your information each year. Complete only the information that has changed, unless otherwise requested. Bring current insurance cards and photo ID.

PATIENT IDENTIFICATION

Patient name: _____ Date of birth: _____

Social Security Number (SSN): _____ - _____ - _____

Today's date: _____ ☐ No changes to contact information

CONTACT INFORMATION

Street address: _____

City: _____ State: _____ ZIP: _____

Cell phone: _____ Home / alternate phone: _____

Email: _____

Preferred contact method: ☐ Call ☐ Text (if offered) ☐ Patient portal ☐ Mail

PRIMARY CARE & EMERGENCY CONTACT

Primary care provider: _____ Phone: _____

Emergency contact: _____ Relationship: _____

Emergency contact phone: _____

INSURANCE VERIFICATION / CHANGES

☐ My insurance is unchanged (please verify cards at check-in) ☐ My insurance has changed

PRIMARY insurance company: _____

Member ID: _____ Group #: _____

Policyholder name: _____ DOB: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SECONDARY insurance company (if applicable): _____

Member ID: _____ Group #: _____

Policyholder name: _____ DOB: _____

PATIENT CONFIRMATION

I confirm that the information above is accurate to the best of my knowledge and will notify the practice of changes.

Signature: _____ Date: _____

CARDIOVASCULAR CARE, P.A.

FINANCIAL POLICY & APPOINTMENT CANCELLATION AGREEMENT

General Financial Policy

Insurance and payments: Copays may be collected at your visit. We may file claims as a courtesy. You are responsible for applicable deductibles, copays, coinsurance and noncovered charges, subject to your insurance plan and law. Please notify us of insurance changes.

Benefits and authorizations: Where permitted, you authorize direct payment of benefits to Cardiovascular Care, P.A. Referrals or prior authorization may be required; authorization does not guarantee payment.

Self-pay and balances: Self-pay patients may request an estimate and information about good-faith estimate rights. Past-due balances are handled according to applicable law and payer agreements.

Office Visit Cancellation & No-Show Policy

24-hour notice: Please call at least 24 hours before your office visit to cancel or reschedule. Missed visits and late cancellations may count as offenses.

First offense: No fee. Written warning letter, automated text or phone reminder when available, and documentation in the chart.

Second offense: \$25 fee. Third and later offenses: \$50 per occurrence. For future nonurgent appointments, live confirmation or, where permitted, payment of outstanding fees or a credit card deposit may be required.

Echo & Nuclear Stress Test Cancellation Policy

24-hour notice: Cancel or reschedule an echocardiogram (Echo) or myocardial perfusion imaging (MPI / nuclear stress test) at least 24 hours in advance.

Echo: \$100 fee for a missed or late-canceled test, starting with the first occurrence (no warning).

MPI / Nuclear Stress Test: \$250 fee for a missed or late-canceled test, starting with the first occurrence (no warning). MPI may require advance ordering of time-sensitive radiopharmaceutical materials and reserved staff/equipment.

Responsibility, Exceptions & Acknowledgment

Fees: No-show charges are administrative fees, not charges for completed medical services. They are not billed as completed services to insurance and apply only where allowed by law, program rules and payer agreements.

Exceptions: Emergencies, illness, hospitalization, severe weather and circumstances outside your control may qualify for management review. Notify the office promptly. Urgent or medically necessary care will not be withheld solely due to an administrative balance.

My acknowledgment: I have read and understand this financial and cancellation policy. I accept responsibility only for charges I am legally required to pay.

Patient name: _____ DOB: _____

Patient / responsible party signature: _____ Date: _____



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PERIPHERAL ARTERY DISEASE (PAD) RISK CHECKLIST

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Complete with the patient. Mark Yes or No for each question. Provide the patient a copy of the completed checklist.

Patient: _____ DOB: _____ Date: _____

QUESTION	YES	NO
RISK FACTORS		
Do you smoke, or have you ever smoked?	☐	☐
Do you have high blood pressure, or take medication to lower blood pressure?	☐	☐
Do you have high cholesterol, or take medication to lower cholesterol?	☐	☐
Do you have diabetes?	☐	☐
Do you have chronic kidney disease?	☐	☐
Have you ever been diagnosed with PAD or heart disease?	☐	☐
Have you ever had a stroke?	☐	☐
Does someone in your family have PAD?	☐	☐
SYMPTOMS		
Do you experience difficulty walking?	☐	☐
Do you experience burning pain in the ball of your foot or toes that worsens when lying down?	☐	☐
Do you experience leg weakness, pain, or cramping when walking or exercising?	☐	☐
Do you have cold feet and/or toes?	☐	☐
Do your legs or feet ever look discolored, pale, or bluish?	☐	☐
Do you have sores or wounds on your legs or feet that heal slowly or do not heal?	☐	☐
Do your toenails grow slowly?	☐	☐
Have you noticed less hair growth on your legs and feet over time?	☐	☐

Questions about PAD? Contact: _____ Phone: _____

Reviewed by: _____ Date: _____

This screening checklist does not establish a diagnosis. Further evaluation may be appropriate based on symptoms and risk factors.



CARDIOVASCULAR CARE, P.A.

NOTICE OF PRIVACY PRACTICES • ACKNOWLEDGMENT

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This page is an acknowledgment of receipt of the practice's Notice of Privacy Practices. It is not a substitute for the complete HIPAA Notice of Privacy Practices, which must be provided or made available separately.

OUR PRIVACY COMMITMENTS

- We collect, use, and disclose health information for treatment, payment, and health care operations, and as otherwise permitted or required by law.
- We apply reasonable safeguards to protect health information and limit access to authorized purposes.
- Patients may request access to or copies of their records, request amendments, request certain restrictions or confidential communications, and obtain information about applicable privacy rights.
- Questions or concerns about privacy practices may be directed to the practice's designated privacy contact.

ACKNOWLEDGMENT

By signing below, I acknowledge that I was offered or received the Notice of Privacy Practices for Cardiovascular Care, P.A. My signature does not waive any rights under HIPAA.

Patient / responsible party name: _____ DOB: _____

Signature: _____ Date: _____

If acknowledgment could not be obtained, office staff may document the reason below:
