



CARDIOVASCULAR CARE, P.A.

NEW PATIENT REGISTRATION • PATIENT INFORMATION

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Please print clearly. Complete all applicable fields and bring your insurance card and photo ID.

PATIENT INFORMATION

Legal name: _____ Date of birth: _____

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

Preferred name: _____ Date completed: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell phone: _____ Home phone: _____ Work phone: _____

Email address: _____

Sex: ☐ Female ☐ Male ☐ Other / prefer to self-describe: _____ ☐ Prefer not to answer

Marital status: _____ Place of birth (optional): _____

PRIMARY CARE AND REFERRAL

Primary care provider: _____ Phone: _____

Referring provider (if different): _____ Phone: _____

How did you hear about us? ☐ Physician ☐ Family/friend ☐ Online ☐ Other: _____

ADDITIONAL DEMOGRAPHICS (OPTIONAL)

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White

☐ Native Hawaiian/Other Pacific Islander ☐ More than one race ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Primary phone: _____ Alternate phone: _____



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NEW PATIENT REGISTRATION • INSURANCE INFORMATION

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Please present all active insurance cards at check-in, including Medicare, supplemental, and secondary coverage.

PRIMARY INSURANCE

Insurance company / plan name: _____

Member / subscriber ID: _____ Group number: _____

Claims phone (if shown): _____ Effective date (if known): _____

Policyholder name: _____ Policyholder DOB: _____

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

Policyholder address (if different): _____

SECONDARY INSURANCE (IF APPLICABLE)

Insurance company / plan name: _____

Member / subscriber ID: _____ Group number: _____

Claims phone (if shown): _____ Effective date (if known): _____

Policyholder name: _____ Policyholder DOB: _____

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

Policyholder address (if different): _____

OTHER COVERAGE

Additional insurance / supplemental plan: _____

Member ID: _____ Group number: _____

Is this visit related to a work injury or motor vehicle accident? ☐ Yes ☐ No

If yes, please advise our registration staff so we can collect the correct billing information.

REGISTRATION VERIFICATION

☐ Insurance cards provided / verified ☐ Photo ID provided / verified

Patient / representative signature: _____ Date: _____

Insurance information is collected for registration and billing. Coverage and benefits are subject to verification.



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NEW PATIENT REGISTRATION • PHARMACY AND MEDICATIONS

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PREFERRED PHARMACY

Pharmacy name: _____

Address / city: _____

Phone: _____

CURRENT MEDICATIONS

List all prescription medications, over-the-counter medications, vitamins, and supplements. Include dose and how often taken.

Medication / supplement	Strength / dose	How often taken

☐ I have provided a separate current medication list. ☐ I do not currently take medications.

MEDICATION SAFETY

Do you take a blood thinner or antiplatelet medication? ☐ Yes ☐ No ☐ Unsure

If yes, name(s): _____



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NEW PATIENT REGISTRATION • ALLERGIES AND CHECKLIST

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MEDICATION ALLERGIES AND REACTIONS

Please list the medication or substance AND the reaction (for example, rash, swelling, breathing difficulty).

Medication / substance	Reaction / symptoms

☐ No known medication allergies ☐ Allergies listed on separate sheet

SPECIFIC ALLERGIES / REACTIONS

Iodinated CT contrast: ☐ Yes ☐ No ☐ Unsure Reaction: _____

Iodine / iodine-containing products: ☐ Yes ☐ No ☐ Unsure Reaction: _____

Latex: ☐ Yes ☐ No ☐ Unsure Reaction: _____

Other allergies (food, adhesive, etc.): _____

WHAT TO BRING TO YOUR FIRST APPOINTMENT

- ☐ Photo ID
- ☐ Primary and secondary insurance cards
- ☐ Current medication list or medication bottles
- ☐ Referral, records, or test results if requested by the office

PATIENT CONFIRMATION

I have reviewed the information I provided and believe it is accurate to the best of my knowledge.

Patient / legal representative signature: _____ Date: _____

Printed name (if representative): _____ Relationship: _____





CARDIOVASCULAR CARE, P.A.

AUTHORIZATION TO SHARE MEDICAL INFORMATION

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Patient name: _____ Date of birth: _____

HEALTHCARE PROVIDERS AUTHORIZED TO RECEIVE INFORMATION

I authorize Cardiovascular Care, P.A. to send relevant medical information to the primary care provider and specialists listed below for coordination of my healthcare.

Primary care provider (PCP)

Name / practice: _____

Phone: _____ Fax / secure contact: _____

Specialist / practice 1

Name / practice: _____

Phone: _____ Fax / secure contact: _____

Specialist / practice 2

Name / practice: _____

Phone: _____ Fax / secure contact: _____

INFORMATION THAT MAY BE SHARED

- ☐ Office visit notes and care plans ☐ Cardiac test results / imaging reports
☐ Medication changes / treatment recommendations ☐ Referral and consultation records
☐ Other (specify): _____

PURPOSE AND AUTHORIZATION

Purpose: Coordination of care and communication with my treating healthcare providers.

This authorization expires (check one): ☐ One year after signature ☐ On this date: _____

I understand that signing this form is voluntary and that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing it, except as permitted by law. I may revoke this authorization at any time by submitting a written request to Cardiovascular Care, P.A.; revocation will not affect disclosures already made in reliance on it. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA, although other laws may apply.

This form does not replace any separate authorization required for specially protected information (for example, certain substance-use treatment records).

PATIENT / LEGAL REPRESENTATIVE SIGNATURE

Signature: _____ Date: _____

Printed name: _____

If representative: Relationship / authority: _____

Note: HIPAA generally permits sharing health information with treating providers without patient authorization. This form documents the patient's requested recipients and preferences; it is not required for routine treatment-related sharing.

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: _____



CARDIOVASCULAR CARE, P.A.

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:
