Palm Coast Cardiovascular Institute
19 Old Kings Road, Suite C106
Palm Coast, FL 32137
386-446-6540

PATIENT INFORMATION:

Name:_____ DOB:_____ SS#:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____ Home Phone #:_____

Cell Phone #:_____ Marital Status:_____

RESPONSIBLE PARTY – ONLY IF NOT PATIENT:

Name:_____ DOB:_____ SS#:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____ Home Phone #:_____

Cell Phone #:_____ Marital Status:_____ Relationship to patient:_____

EMPLOYMENT INFORMATION:

Employer:_____ Office Phone #_____

Address:_____ Occupation:_____

PRIMARY INSURANCE:

Company:_____ Insured Name:_____

Claims Address:_____ Insured DOB:_____

Phone #:_____ ID#:_____ Group #:_____

SECONDARY INSURANCE (IF APPLICABLE)

Company:_____ Insured Name:_____

Claims Address:_____ Insured DOB:_____

Phone #:_____ ID#:_____ Group #:_____

EMERGENCY NOTIFICATION / NEXT OF KIN – SOMEONE NOT IN HOUSEHOLD

Name:_____ Relationship to patient:_____

Home Phone #:_____ Work Phone #:_____

Address:_____ City:_____ State:_____ Zip Code:_____

AUTHORIZATION FOR RELEASE OF PERSONAL MEDICAL INFORMATION:

I understand, as outlined in the Notice of Patient Privacy Practices, my personal medical information will only be released as it pertains to my medical treatment, payment of charges, or operation of the practice. I understand I have the right to request that we restrict how protected information is used or disclosed. We are not required to agree, but if we do, we are bound by our agreement. I also understand that I have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent. The practice is also authorized to release my personal medical information to the following individual (s):

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physician. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I understand and agree that, regardless of my insurance status, I am responsible for any balance of my account and understand that if I do not pay my balance, my account may be forwarded to a collection agency and that I would be responsible for their fee as well.

_____

Patient Signature or Responsible Party Signature Date

Palm Coast Cardiovascular Institute

Patient Rights and Responsibilities

Patient Rights:

1. You have the right to dignified and respectful care.
2. You have the right to know about and understand your physical condition.
3. You have the right to obtain any information requested by you to give informed consent before any treatment and/or procedure.
4. You have the right, at you own expense, to consult with another physician or specialist.
5. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal.
6. You have the right to be treated in a safe environment that is free of physical and psychological threats.
7. You have the right to privacy regarding visitors, mail and/or telephone conversations.
8. You have the right to expect that all communications and records regarding your care will be held confidential.
9. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice.
10. You have the right to communicate verbally or in writing with anyone outside the practice and to expect that an interpreter will be provided if language is a barrier.
11. You have the right to know the identity, professional status, and institutional affiliation of anyone treating you.
12. You have the right to request an itemized statement of all services provided to you through this practice.
13. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.
14. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

Patient responsibilities:

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.
2. You will be responsible for participating in the development of your plan of care.
3. You will be responsible for attending scheduled therapy and participating in activities prescribed by your treatment plan.
4. You will be responsible for considering the right of other patients and office personnel during your treatment in this practice.
5. You will be responsible for following practice rules and regulations.
6. You are responsible for updating contact information; telephone and address..

Concern/Complaint Procedure

We want to hear from you if you have any concerns, complaints, or compliments regarding your stay treatment and care in our practice. Please inform any staff member.

Response to a concern/complaint will take place within 24 hours. Concerns/complaints will be monitored and the information utilized to improve our program.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.

Date:_____ **Patient**:_____

Caregiver and relationship: _____

Witness: _____

Witness: _____

(if patient is unable to document signature, two persons must be witness)

Updated December 12, 2014

Palm Coast Cardiovascular Institute

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send a prescription directly to a pharmacy from the point of care. The government has determined that the ability to electronically send prescriptions is a necessary element in patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing program. These include:

- **Formulary and benefit transactions –** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions –** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form you are agreeing that Palm Coast Cardiovascular Institute can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.
Understanding all of the above, I hereby provide informed consent to the Palm Coast Cardiovascular Institute to enroll me in the E-Prescribe Program. I have had a chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient Name Patient DOB

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

Updated February 22, 2014