MHC CARDIOLOGY CLINIC

Welcome to MHC Cardiology Clinic

LEONARD SAVINO, MD
Board Certified Cardiologist

We are very pleased to note that you have chosen us as your **Cardiac Healthcare Provider**. We understand that there are a lot of providers in the market and are glad you have chosen us. We promise to do our very best to help you achieve/ maintain your Healthcare goals in the years to come. **Welcome to MHC Cardiology Clinic.**

Please find a packet with the forms you will need to bring with you during your first visit. Please note that completing the forms and answering the questionnaire to the best of your possible ability is extremely important for your provider to understand you and to provide you with Healthcare treatment plans/ options to best suit your customized/ special needs.

We do ask that you arrive at least 20 minutes early for your first appointment and at least 10 minutes early for your regular/ follow-up appointments – in order to allow time to complete any front-office formalities prior to being triaged and then seeing your provider. Please bring all your current **identification (ID) cards**, current **medication bottles** (not just lists) and **reports from other providers** (if any) to our office **for every visit**, so we can understand your medical needs fully.

Please note that you have been referred to us by your Primary Care Provider. You are requested to continue seeking Primary Care from your existing Primary Care Provider.

Please feel free to contact our office if you have any questions.

Phone #: 352-274-9900
Fax #: 877.405.0955

Welcome to our practice. We look forward to meeting your healthcare needs.

Sincerely,

Your Cardiology Clinic Team!

1714 SW 17th Street, Ocala Florida 34471
GoToMHC.com

MHC CARDIOLOGY CLINIC

Important Points to Know Before Your Visit

We are "Participating" Providers with several insurances including Medicare, Freedom, Optimum, Coventry, Wellcare, BCBS, etc. All physicians' offices which treat patients must choose to function either as a "participating provider" or as a "nonparticipating" provider. The main difference has to do with how fees are established and who pays. We as participating providers have agreed to reduce our fees substantially and to collect only a portion as determined by your contract with your insurance of that specially reduced fee from you (after the deductible has been met). The other portion of the discounted fee is reimbursed by your insurance to our office. Please note – with the number of insurances and number of different plans within each insurance in the market – it is your responsibility to check with your insurance if they will cover for your visit to our offices or not. We will do our best to bill your insurance and get paid by them. However, if your insurances denies payment, you will be responsible for payment.

Not All Medical Services Are "Covered" by Medicare/ other insurances: Periodically a patient might need a medical service which Medicare/other insurances do not cover, or which Medicare does cover, but only in certain circumstances, such as a CGM/MedGem. For example, the patient in room #1 might need a chest x-ray because she has pneumonia. The patient in room #2 might need a chest x-ray because she has a chronic cough, but does not have pneumonia. Medicare "covers" (pays for) the first patient's x-ray, but not the second patient's x-ray. Because of this policy, the first patient will only pay 20% of the discounted x-ray fee, but the second patient will have to pay 100% of the fee which non-Medicare patients are charged. This is determined by your insurance and not by our office.

Getting Established: In order to take proper care of you, we need to know who we're taking care of! This requires that we spend a time early in your relationship with us (usually your first or second visit) where we ask you about your past medical history, your family history, your lifestyle, your allergies, etc. It almost always requires some very basic additional tests, such as blood work, EKG, etc. Meaning, a patient might feel "All I need is to have my blood pressure prescription refilled and my last doctor up north took care of my "physical" just recently". Once we become responsible for refilling a prescription, we become responsible for knowing your current medical details. Ironically, this "get-acquainted" evaluation is often only partially "covered" by Medicare, or sometimes completely "non-covered". Nonetheless, it is still the most important part of your becoming enrolled as a patient in our practice.

Deductible (Depending on your plan): Each year (beginning January 1st) Medicare requires that patients pay a deductible before Medicare itself begins to pay benefits. After meeting this deductible, patients usually pay only 20% of specially reduced fees. Therefore, it is very important for us to know when you have met your deductible! If your deductible has been partially met or fully met elsewhere (i.e. in another doctor's office or hospital) it is necessary that you bring us a copy of your Medicare statement which indicates this. Please remember that any charges which Medicare does not "cover," of course, do not count toward meeting the deductible.

Payment at Time of Service: Our participation in the sometimes overwhelming Medicare/ other insurance systems is a courtesy which we respectfully offer the seniors of our community. We ask in return that all patients plan to pay any co-pay, deductible, or non-covered services on the day services are rendered. For the convenience of our patients, we accept Visa, MasterCard, Cash and personal checks.

Medical Home: Several insurance plans, especially Medicare Advantage plans (HMO), have decided to opt to work under the "Medical Home" concept. Our contracts as well as your contracts with these insurance plans require us to operate under a set of rules/ regulations/ guidelines – specific to these plans. This may include requirements such as (a) you have to be seen by your Primary Care Provider prior to being referred out to any specialists, (b) you have to get certain procedures/ diagnostics done only at your PCP office (or an office determined by your PCP), (c) you have to stay within the network of providers that are participating with the plan etc. Such guidelines have been established to ensure that you obtain the best possible care for your conditions at the best possible time/ cost/ manner and for the most part – remain as close to your PCP as possible – who will be your Medical Home – one-stop-shop for your Medical needs. If you have opted to choose one of these plans, please be aware of such guidelines and cooperate with us wholeheartedly.

Please note that you have been referred to us by your Primary Care Provider. You are requested to continue seeking Primary Care from your existing Primary Care Provider.

MHC CARDIOLOGY CLINIC

PLEASE PRINT CLEARLY (Please bring your Driver's License and current Insurance cards)

Last name: ___________________________ First Name: ____________________ Mid Initials.: _____

Social Security Number: ___________________ DL/ State ID#: ____________________ DOB: ___________ Sex: ____

Race: ____________________ Ethnicity: ____________________ Preferred Language: _____________________

Mailing address: _____________________________________ City: _______________ State: ___ Zip: _____________

Physical address: _____________________________________ City: _______________ State: ___ Zip: _____________

Home Phone: (____) ____-______ Cell Phone: (____) ____-______ Email address: ___________________________

Marital Status: ________ Spouse's name: _______________ DOB: __________ SSN: ______________________

<u>If under 18:</u> Parent/ Guardian's name: _____________________________DOB: __________SSN: ______________________

Employed: Yes/No Full-time student: Yes/ No Part-time student: Yes/ No

Employer/ School name: ____

Employer/ School address: __________________________________ City: _______________ State: ___ Zip: ________

Primary Insurance name (attach copy of card): ____
Primary Insurance Policy#: ___________________________ Group#: ____________________________
Primary Insured's name: __________________________ Primary Insured's SSN: _____________________________

Secondary Insurance name (attach copy of card): ____
Secondary Insurance Policy#: ___________________________ Group#: ____________________________
Secondary Insured's name: __________________________ Secondary Insured's SSN: _________________________

If you are being referred to us by another physician, please complete below:
Referring Physician Full name (no abbreviations): ____
Referring Physician Fax number: ____Fax notes to referring physician: Yes/ No

Emergency contact (someone who does not live in your home)
Emergency contact name: __________________________________
Emergency address: ____________________________________ City: _______________ State: ___ Zip: _____________
Emergency Home Phone: (____) ____-______ Emergency Cell Phone: (____) ____-______

By signing below, I acknowledge that I have received, read and understood the HIPAA Notice of Privacy Practices of Physician Partners Specialty Services LLC (PPSS) (Available on the website and copy available on request at the office) and authorize PPSS to release or obtain any relevant information to or from any related third-party. I also authorize PPSS to bill any relevant third party for the services rendered and to bill me for any balances after payment from such third-parties. I also authorize PPSS to bill me for any fees/ costs/ charges associated with collecting monies due to them on my behalf.

Patient /Legal representative Signature: ____ Date: ______________________

MHC CARDIOLOGY CLINIC

PATIENT QUESTIONNAIRE

Patient Name: ________________________________ Date of Birth: ___/____/________
Sex: Female / Male SSN: ___________________________

Other doctors that you are currently seeing (Note: If you need referrals in future, you need to identify your doctors here)		
Doctor's full name	**Address, City, State, Zip**	**For what condition?**

Name of your Pharmacy:	**Pharmacy Phone #:**
Allergies:	**Reason for today's visit:**

Past Medical History/ Family History							**CURRENT MEDICATION LIST:**		
Condition	**Self**	**Father**	**Mother**	**Siblings**	**Children**		**Medication**	**Dose**	**Times/day**
Heart Attack									
Valve disorder									
High Blood Pressure									
Diabetes									
Colon Cancer									
Breast Cancer									
Prostate Cancer									
Other cancer (specify)									
High cholesterol									
Mental illness									
Depression									
Stroke									
Osteoporosis									
Seizures/ Epilepsy									
Migraine									
Liver Disease									
Kidney Disease									
Neuro problems									
Arthritis									
Bleeding disorder									
Thyroid problems									
Alcohol or Drug abuse									
Accidents (specify)									
Surgery (Specify)									
Hospitalization (Specify)									
Hospitalization (Specify)									

Social History

Do you smoke? Yes/ No. If Yes, How many? ___________; if not, are you a past smoker? Yes/ No. When did you quit? __________.
Do you drink alcohol? Yes/ No. If Yes, How much? ______
Do you have any drug or other allergies (please specify) ____

When was your last test/ exam/ shot/ treatment for (Please provide exact dates and where you got it – This is IMPORTANT).

Mammogram:	Eye:	Dental:	Cholesterol:
Colonoscopy:	Glaucoma:	Prostate:	Breast:
Stool Blood:	PAP Smear:	Ear:	

MHC CARDIOLOGY CLINIC

PATIENT QUESTIONNAIRE – REVIEW OF SYMPTOMS

Patient Name: ___________________________________ **Date of Birth: ___/____/________**

GENERAL	EYES / EARS	GASTROINTESTINAL
• Weakness • Fatigue • Fever • Dizziness • Headaches • Weight loss • Weight gain • Others _______________ • None	• Blurred vision • Glaucoma • Double vision • Others _______________ • None --- • Hard of hearing • Deafness • Ringing • Room spinning • Others ________________ • None	• Abdominal pain • Nausea/ vomiting • Indigestion • Constipation • Blood in stool • Irregular bowels • Food intolerance • Heartburn • Others _______________ • None
HEART	**ENDOCRINE**	**GENITOURINARY**
• Blood clots • Chest pain • Chest pressure • Fainting • Murmur • Palpitations • Rapid heart beat • Swollen legs • Others _______________________ None	• Diabetes • Hypoglycemia • Heat/ cold intolerance • Loss of hair • Erectile dysfunction • Others _________________ • None	• Kidney stones • Urination at night • Blood in urine • Others _________________ None
LUNGS	**MUSCULOSKELETAL**	**GYNECOLOGICAL**
• Cough • Shortness of Breath • Wheezing • Asthma • Chest pain • Congestion • Blood • Phlegm • Others _________________ • None	• Pain • Cramps • Joint pain/ stiffness • Back pain • Joint swelling • Injuries • Weakness • Others ________________ • None	• Post-menopausal • Hot flashes • Others __________________ • None
NEUROLOGICAL	**PSYCHIATRIC**	**MOUTH/ THROAT/ NOSE**
• Seizures • Hand trembling • Slurred speech • Shuffling gate • Tingling/ Numbness • Paralysis • Weak grip • Loss of Sensation • Others _______________ • None	• Depression • Poor sleep • Anxiety • Panic attacks • Suicidal thoughts • Others _______________ • None	• Bleeding • Hoarseness • Hard to swallow • Loss of taste • Gum problems • Others __________________ • None --- • Nose bleeds • Others ________________ • None

MHC CARDIOLOGY CLINIC

INSURANCE ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION: I, the below named patient, do hereby authorize ay physicians examining and/or treating me to release to any third payer (such as an insurance company or governmental agencies, e.g., BC/BS of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for it use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASIGNMENT: I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID: Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIIXIX of the Social Security Act is correct. I authorize any holder of medical or any other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician threatening me.

PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENT TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE: The assignment will remain in effect until revoked by me in writing.

<u>CONCENT FOR TRETMENT</u>**: I, the below named patient hereby give my consent for treatment to all physicians associated with Physician Partners Specialty Services, LLC.**

CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do hereby authorize Physician Partners Specialty Services, LLC. To discuss my medical condition with, or release my medical records to the below named person(s):

Name: ____ Relationship to Patient: _________________________

Name: ____ Relationship to Patient: _________________________

NO SHOWS / LAST MINUTE CANCELATIONS / LAST MINUTE RESCHEDULES: Providers and staff of Physician Partners Specialty Services LLC rely on the pre-schedule appointments to plan day to day activities. Last minute reschedules or cancelations and no-shows disrupt the daily activities and also curtail the ability to schedule another patient in your pre-scheduled slot. If you have to cancel or re-schedule your appointment, **we may charge a $25.00 fee** directly to you. Please note that this charge will not be billed to any third party (including your insurance) but directly to you and you will be responsible for payment of this charge prior to any further encounters.
COLLECTION AGENCY: In the event your account becomes delinquent and is turned over to a collections agency and/or attorney, you will be financially responsible for all associated collection fee and legal fees that Physician Partners Specialty Services, LLC incurs through the process utilized to collect the delinquent balance. Please be aware if your account is turned over to a collections agency, you may be discharged from the practice.
RETURNED CHECK: Checks returned to Physician Partners Specialty Services, LLC by the bank will be assessed a return check fee, in addition to the original amount of the check. You have the (10) days to clear up the outstanding check. If you fail to pay the due amount, your account will be referred to the collections agency and we may discharge you from the practice.

Please remember that insurance is considered a method of reimbursing the services provided. You are responsible to pay any co-pay, deductible amount, co-insurance or any other balance not paid for by your insurance or third party payer within a reasonable period of time not to exceed sixty (60) days from the day you receive notification.

Acknowledgement:

Patient / Legal representative signature: ____ Date: ___________________

MHC CARDIOLOGY CLINIC

HIPAA Authorization Consent for Release of Medical Information

Patient Name: ____

Address: ____

Date of Birth: __________________ Medical Records #: _____________________________

Date(s) of Treatment: _____________ Release Information to: ____
(Name of individual or organization)

Address: ____ Phone #: ___________ Fax #:__________________

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization or outpatient care

_____ Drug and alcohol treatment care

_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

_____ Emergency room visit

_____ Psychiatric care *requires special consent

I am requesting the following information to be released:

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)

_____ Entire medical record

_____ Other _____Labs _____Slides ** _____X-rays**

I authorize permission for this confidential information to be released for the following purpose:

_____ Continue medical treatment _____ Litigation for review _____ Insurance ___________

Other: Specify Reason: ____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS: I Understand the following: See CFR 164.508(c) (2) (I-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

____ ____________________

Signature of Patient or Legally Authorized Representative **Date**

____ ____________________

Name of Legally Authorized Representative to Patient **Relationship to Patient**

**I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc. A request may take 30 working days to process. If you do not receive the records within 30 days, you should call MHC Medical Records Department at #352.274.9900

MHC CARDIOLOGY CLINIC

HIPAA AUTHORIZATION TO OBTAIN PATIENT MEDICAL INFORMATION
PLEASE FAX BACK TO # 877-405-0955

Records to be released from: ____

Fax #: __________________________________ **Phone #**: ______________________________________

Patient Name: ____

DOB: ___________________________________ **Social Security Number**: ______________________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation from the above-named doctor or health care provider to:

Requesting Provider: **____** Phone **#: 352.274.9900**

Requested Information

- All records
- Office Visit notes – last two only
- Cardiology reports only
- Consults notes only
- Office notes only
- Lab reports only
- Radiology reports only
- Hospital records only
- Other ____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS - I understand the following (see CFR 164.508(c)(2)(i-iii)):

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to 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 conditioned on the signing of this authorization.

____ ___________________________

Signature of Patient or Legally Authorized Representative **Date**

____ ___________________________

Name of Legally Authorized Representative for Patient **Relationship to Patient**

MHC CARDIOLOGY CLINIC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14**,** 2003, and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Ram Moorthy. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

- **Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
- **Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you *choose* to involve in your care, only if you agree that we may do so.
- **Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
- **Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.
- **Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, and individuals performing similar activities.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law: court or administrative orders, subpoena, discovery request or other lawful process. We will use and disclose your information when requested by national security intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
- **Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability.
- **Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.
- **National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

- **Access:** Upon written request, you have the right to inspect and get copies of your health information, and that of an individual for whom you are a legal guardian. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the form.
- You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page up to 25 pages, then 25 cents each page thereafter, and the staff time charged will be $50.00 per hour including the time required to locate and copy your health information. If you want the copies mailed if you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.
- **Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
- **Non-Routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations.
- You can request non-routine disclosures going back six (6) years starting on April 14. 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)
- **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

<u>HOW TO CONTACT US</u>:

Privacy Officer: Ram Moorthy
Mailing address: PO Box 4590, Ocala, FL 34478-4590
Phone: (352) 509-9900; Fax: (352) 484-1159
Website: www.fmahealth.com

This form does not constitute legal advice and covers only federal, not state, law.