WELCOME TO CELANO CARDIOLOGY

PLEASE PRINT – NEW PATIENT PAPERWORK

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

DOB: _____ SSN: _____ SEX: MALE / FEMALE

HOME ADDRESS: _____

HOME #: _____ CELL #: _____ OPT IN FOR TEXT ALERTS? Y / N

EMAIL ADDRESS: _____ PORTAL SIGN UP? Y / N

EMERGENCY CONTACT: _____ HIPPA? Y / N

RELATIONSHIP: _____ PHONE: _____

DO YOU HAVE AN ADVANCED DIRECTIVE/LIVING WILL? Y / N

PRIMARY CARE PHYSICIAN (PCP) _____ PCP PHONE: _____

PCP ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY # / SUBCRIBER ID: _____ GROUP #: _____

- IF DIFFERENT FROM ABOVE PLEASE FILL OUT

INSURED NAME: _____ DOB: ___/____ / _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____

POLICY # / SUBCRIBER ID: _____ GROUP #: _____

- IF DIFFERENT FROM ABOVE PLEASE FILL OUT

INSURED NAME: _____ DOB: ___/____ / _____

RELATIONSHIP TO PATIENT: _____

MEDICAL HISTORY

NEW PATIENT APPOINTMENT: _____

REASON FOR SEEING CARDIOLOGIST: _____

HAVE YOU SEEN ANOTHER CARDIOOGIST BEFORE? Y / N WHO? _____

CURRENT SYMPTOMS (Circle all that apply)

Dizziness	Swelling/Fluid Retention	Sleep Apnea
Shortness of Breath	GERD/Acid Reflex	Peripheral Vascular Disease
Chest Pain	Palpitations	Leg Pain
Syncope/Fainting	Numbness/Tingling	Abnormal Heart Rhythm
Headaches	Heart Murmur	Previous Stroke/TIA
Nausea/Vomiting	PVA/PAC	Abdominal Aortic Aneurysm

Other: _____

Previous Conditions or Diagnosis (Do you have any of these conditions?)

High Blood Pressure	Low Blood Pressure	Heart Valve Replacement
Diabetes	COPD/Asthma/Lung Disease	High Cholesterol
Stroke	Stents or Bypass Surgery	Bleeding Problems
Pacemaker or Defibrillator	Carotid Artery Disease	Atrial Fibrillation

Please list any other conditions: _____

SURGICAL HISTORY (Please include dates)

If you have never had any surgeries, please check the box to the right. ☐ No surgeries

_____		_____	
Surgery	Date	Surgery	Date
_____		_____	
Surgery	Date	Surgery	Date

When was your last: (Please add location below)

EKG: _____ Stress Test: _____ Echo: _____

SOCIAL HISTORY

Alcohol: ☐ Never ☐ In the past _____ ☐ Currently : How much/How often? _____

Tobacco: ☐ Never ☐ In the past _____ ☐ Currently : How much/How often? _____

Caffeine: ☐ Never ☐ In the past _____ ☐ Currently: How much/How often? _____

Exercise: ☐ I do not exercise ☐ Currently: How much/How often? _____

Family History (Please list living or deceased and diagnoses and conditions)

Father: _____ Mother: _____

Brother(s): _____ Sister(s): _____

Son(s): _____ Daughter(s): _____

ALLERGIES / INTOLERANCES

If you have no allergies, please check the box to the right. ☐ No allergies

1. _____
2. _____
3. _____
4. _____
5. _____

CURRENT MEDICATIONS

If you take no medications, please check the box to the right. ☐ No medications

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

PHARMACY: _____ PHARMACY PHONE: _____

Signature: _____

Date: _____

Patient Responsibility Form

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITIES**
    a. I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered services.
    b. I understand that I am responsible for any payment should I provide the wrong insurance card or an inactive insurance card at the time of my visit.
    c. Co-payments are due at the time of service.
    d. If my plan needs a referral, I must obtain it prior to my visit.
    e. If my health plan determines a service to be "not payable" I will be responsible for the complete charge and agree to pay the costs of all services provided to me.
    f. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.
2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
    a. I hereby authorize and direct payment of my medical benefits to Celano Cardiology on my behalf for any services furnished to me by the providers.
3. **AUTHORIZATION TO RELEASE RECORDS**
    a. I hereby authorize Celano Cardiology to release to my insurer or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical providers.
4. **MEDICARE REQUEST FOR PAYMENT**
    a. I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Celano Cardiology. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name Date

Celano Cardiology
3607 15th Ave.
Vero Beach, FL. 32960
Ph. 772-360-1799. Fax. 772-494-6700

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: ( ) _____
Date of Request: _____ **Date Needed:** _____

OR

☐ I authorize Celano Cardiology **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #

_____
Fax # (include area code)

☐ I authorize Celano Cardiology **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #

_____
Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

☐ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
☐ Specific information (Select one or more, as applicable)
- ☐ Procedure report ☐ History & physical ☐ Physical Therapy ☐ Laboratory test results
- ☐ X-ray reports ☐ Other _____ (Please describe.)

☐ Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only.
☐ One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **and** for medical records of any **future** treatment of the type described above until: _____ Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____

Cleveland Clinic

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION THROUGH DRCONNECT

Cleveland Clinic DrConnect Operations
Phone: 877.224.7367 (877.CCHS.EMR)
Fax: 216.445.9668
Email: drconnect@ccf.org

Patient:_____ SSN:_____

Clinic #: _____ Date of Birth: _____ / _____ / _____

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

Telephone: _____

I hereby authorize the Cleveland Clinic and its affiliates (collectively, "Cleveland Clinic") to release my health information as indicated below. **I understand and acknowledge that this release will include records of any treatment I have received for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results, diagnoses and treatment. This authorization does not include permission to release Psychotherapy Notes as defined below.* The release of Psychotherapy notes requires a separate authorization.**

Release To: DR. CHARLES CELANO Telephone: 772-360-1799

Address: 3607 15TH AVE SUITE A City: VERO BEACH State: FL Zip: 32960

Reason for disclosure: CONTINUATION OF CARE.

Information to be disclosed: I understand and agree that my **complete and full medical record** will be released regardless of dates of treatment. The information released will include, but not be limited to, the following records:

•Alcohol and/or drug abuse treatment records •Mental health treatment records including treatment for mental illness •HIV tests, results, diagnosis and treatment
•Discharge summaries • History & physical •Laboratory reports •Operative reports •Pathology reports •Medications •Clinic/Progress notes •Diagnoses

This authorization is subject to revocation at any time except to the extent the action has been taken thereon. I may revoke this authorization at any time by contacting Cleveland Clinic at the contact information listed above. I understand that the recipient of my health information may be charged for the service of releasing medical information.

This authorization will expire one hundred eighty-five (185) days from the date written below, unless I specify an earlier date: _____ _____. I understand that information released pursuant to this authorization may remain part of my permanent medical record at Recipient. My health care (or payment for care) will not be affected by whether or not I sign this authorization. Once my health information is released, redisclosure of my health information by the Recipient may no longer be protected by law.

NOTICE TO RECIPIENT OF INFORMATION & ADDITIONAL PATIENT ACKNOWLEDGEMENT

The information disclosed pursuant to this authorization will contain any and all information contained in my medical record that is protected by Federal confidentiality rules relating to treatment provided by Alcohol and Drug Abuse Program (42 C.F.R. Part 2) and state law pertaining to the disclosure of HIV/AIDS information. **These rules prohibit Recipient from making any further disclosure of this information** unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 relating to the disclosure of alcohol and drug abuse program information or state law pertaining to disclosure of HIV/AIDS information. A general authorization for the release of medical or other information is NOT sufficient for these purposes. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ / _____ _____ / _____ / _____

*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____

Relationship if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.*

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*