



# Charlotte Heart & Vascular Institute

## History and Physical

Room # \_\_\_\_\_

**Please answer all info below**

Date: \_\_\_\_\_ Chart # \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Doctor: \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Dr. \_\_\_\_\_

Pharmacy used: \_\_\_\_\_ Lab used: \_\_\_\_\_

**Do you have, or have you ever had any of the following? Please circle all that apply.**

- |                         |                     |                   |                  |
|-------------------------|---------------------|-------------------|------------------|
| Weight loss             | Lung disease        | Nausea            | Diabetes         |
| Fever/ Chills           | Asthma              | Vomiting          | Thyroid Disease  |
| Night Sweats            | Bronchitis          | Diarrhea          | Arthritis        |
| Prior Heart attack      | Pneumonia           | Blood in stool    | Gout             |
| Chest pain/ Angina      | Emphysema           | Ulcer             | Muscle Aches     |
| Irregular heart beat    | Shortness of breath | Hiatal Hernia     | Blood clots      |
| Leg cramping            | Head Aches          | Hepatitis         | Anemia/ Bleeding |
| High blood pressure     | Seizures            | Gallstones        | Cancer of _____  |
| High cholesterol        | Dizziness           | UTI               | Depression       |
| Heart murmur            | Fainting            | Urination @ night | Anxiety          |
| Rheumatic fever         | Swelling/ Edema     | Blood in urine    | Heart Failure    |
| Pacemaker/ Defib: _____ |                     | Type: _____       |                  |

### **Drug Allergies (Please list)**

\*Are you allergic to IV dye, Iodine or Shellfish

<b><u>Surgeries</u></b>	
<b><u>Date</u></b>	<b><u>Surgery</u></b>

### **Social History:**

Occupation \_\_\_\_\_ Retired Y / N  
 \_\_\_ Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Divorced  
 Tobacco: Packs daily \_\_\_\_\_ How long? \_\_\_\_\_ When quit? \_\_\_\_\_  
 Coffee: Cups daily \_\_\_\_\_ Decaf / Regular \_\_\_\_\_  
 Alcohol: Type & amount \_\_\_\_\_  
 Exercise Routine: What type & how often? \_\_\_\_\_

### **Current Medications**

\*List all meds and doses

<b><u>Family History</u></b>	<b><u>Father</u></b>	<b><u>Mother</u></b>	<b><u>Siblings</u></b>
Age	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood pressure	_____	_____	_____
Stroke	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____

**(Office use only)**

HT \_\_\_\_\_ WT \_\_\_\_\_ HR \_\_\_\_\_ BP \_\_\_\_\_ Reason for visit: \_\_\_\_\_



# Charlotte Heart & Vascular Institute

## PAD Assessment (Peripheral Artery Disease)

Today's Date: \_\_\_\_\_

FIRST NAME


LAST NAME

DATE OF BIRTH

Peripheral Artery Disease (PAD) is a common circulation problem, in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PAD.

**✘ Circle YES or NO on the following questions and check all boxes that apply:**

1. Have you ever been diagnosed with Peripheral Vascular Disease as having poor circulation? <b>YES NO</b>	6. If you have pain, does the pain subside with rest? <b>YES NO</b>
2. Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, belly, legs, or arms? <b>YES NO</b> If yes, dates: _____	7. Do your feet or toes bother you at night while lying in bed? <b>YES NO</b> Is discomfort relieved when they are dangled at the edge of the bed? <b>YES NO</b>
3. When you walk, do you experience aching, cramping, or pain in your legs, thighs or buttocks? <b>YES NO</b>	8. Do you have any painful sores or ulcers on legs or feet that do not heal? <b>YES NO</b>
4. If you answered Yes to #3, when do you feel the pain: <input type="checkbox"/> After walking 1 block. <input type="checkbox"/> Climbing a flight of stairs. <input type="checkbox"/> After walking 100 yards. <input type="checkbox"/> Walking at increased speed.	9. Are your legs discolored or bluish? <b>YES NO</b>
5. If you answered Yes to #3, circle the area (s) of the body on the diagram below where you feel pain.	10. Check all that apply: <input type="checkbox"/> I am a current smoker <input type="checkbox"/> I have a history of smoking <input type="checkbox"/> I have diabetes <input type="checkbox"/> I have a family history of diabetes <input type="checkbox"/> I have high cholesterol <input type="checkbox"/> I have a family history of high cholesterol <input type="checkbox"/> I have high blood pressure/ hypertension <input type="checkbox"/> I have a family history of high blood pressure/ hypertension <input type="checkbox"/> I have/ had coronary artery disease (CAD)/ heart attack <input type="checkbox"/> I have a family history of coronary artery disease/ heart attack <input type="checkbox"/> I have had a stroke/ mini-stroke/TIA <input type="checkbox"/> I have a family history of stroke/ mini-stroke/TIA
	



# Charlotte Heart & Vascular Institute

## Our Financial Policy

In an effort to control costs and provide the best possible care for our patients, we have established the following financial policy. We hope that this will answer any questions you may have in regard to your financial responsibilities.

1. All insurance co-pays and deductibles are due at the “time of service”. For your convenience, we accept Visa, MasterCard, Discover, debit card, personal checks, and cash as forms of payment at our facility. If your check is returned to us for any reason, you will be charged a \$25.00 fee.
2. Uninsured/ Self- pay patients are required to pay a “good-faith” deposit of \$250.00 upon your first office appointment. If our services are more than \$250.00 you will also be required to meet with our financial department to arrange a payment plan for any future charges.
3. Keep in mind that your insurance coverage is an agreement between you and your insurance company. As a courtesy to our patients, we will file your initial claim for you. For Medicare patients, we will file your secondary & additional insurance as well. If payment is not received within 30 days, or a balance remains after payments are received from your insurance company, you may be billed for the balance. Insurance payments made directly to the patient for CHVI services rendered are due to CHVI immediately.
4. Not all insurance plans cover all services. If your insurance company determines a service is “not covered”, you will be responsible for the balance. Additionally, if your insurance company only covers a percentage of the service, you are responsible for the remaining portion.
5. In the event that you have a “patient due” balance on your account at the time of a visit, you will be asked to bring your account current prior to your appointment with the Doctor. If you are unable to do this, upon completion of a financial disclosure, our Financial Department will be happy to work out a “payment plan” with you.

6. For all outstanding balances, a payment plan structure may be set up as follows:

<u>Balance Due</u>	<u># of Months</u>
Less than \$100	2
\$100.01-\$300	3
\$300.01-\$500	4
\$500.01-\$800	6
\$800.01-\$1500	8
\$1500.01-\$2500	10
\$2500.01-\$4000+	12

7. Any accounts with an outstanding balance after 90 days of notice, without pending insurance and/or financial arrangements, will be sent to an outside collection agency. If this is the case, you may be required to pay for any further appointments or test, in full, on the day of service.
8. A patient under the age of 18 must be accompanied by a parent or legal guardian to authorize treatment and make financial arrangements. If a custodial parent is present but does not carry the patient on their personal insurance, we can submit charges to the patient’s insurance provider. However, the parent presenting the child will be billed for any balance uncovered by the patients insurance. Patients 18 and over are financially responsible for charges incurred during each visit.



# Charlotte Heart & Vascular Institute

9. We require notification at least 24 hours in advance if you are unable to keep your Doctor appointment(s) to avoid a \$25.00 no-show fee. No-show fee for Echo & Nuclear testing is \$75.00. No-show fees will be billed to your account since insurance companies will NOT pay.
  
10. We will make every effort to work with you; however, reasons such as but not limited to, failure to keep appointments, non-compliance with prescribed treatment plan, abusive behavior toward staff members, and/or failure to pay your bill may result in dismissal from the practice. If dismissed from CHVI, you are eligible for emergency treatment only. Emergency care is provided for a maximum of 30 days. After that time, you will be required to seek medical treatment from another physician/ practice.

*I have read and understand Charlotte Heart & Vascular Institute's (also referred to above as CHVI) policy and I agree to be bound by its terms. I also understand that such terms may be amended without notice by Charlotte Heart & Vascular Institute at any time.*

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Signature of Patient (or responsible party, if under 18)

Date

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Print name of Patient

Date of birth

Patient account #



# Charlotte Heart & Vascular Institute

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below acknowledges that I have received Charlotte Heart & Vascular Institute's Notice of Privacy Practices pamphlet and had the opportunity to ask questions regarding this notice.

X \_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

## Authorization to Disclose Information to a Third Person

I, \_\_\_\_\_ authorize Charlotte Heart & Vascular Institute to release my protected health information to the person(s) listed below under the circumstances indicated. (Please initial the information you wish to be shared.)

_____	Without limitations
_____	Financial records
_____	Medical records
_____	Only if I become incapacitated

\_\_\_\_\_ Authorized Person (please print)

Relationship to patient: \_\_\_\_\_

Contact's phone#: \_\_\_\_\_

_____	Without limitations
_____	Financial records
_____	Medical records
_____	Only if I become incapacitated

\_\_\_\_\_ Authorized Person (please print)

Relationship to patient: \_\_\_\_\_

Contact's phone #: \_\_\_\_\_

X \_\_\_\_\_

Authorization Patient signature

\_\_\_\_\_

Date

OR

I choose NOT to release any of my health information to individuals (including my spouse) at this time, except as required by law, as stated in the Notice Privacy Practice.

X \_\_\_\_\_

Authorization Patient signature

\_\_\_\_\_

Date

Port Charlotte· 3340 Tamiami Trail, Port Charlotte, FL 33952· 941-764-5858· Fax 941-764-1657  
Punta Gorda· 25097 Olympia Avenue, Suite 102, Punta Gorda, FL 33950· 941-235-7100· Fax 941-639-3805



# Charlotte Heart & Vascular Institute

## Medical Records Release

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Cardiac Catheterization Lab  
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 105 Punta Gorda, FL 33950  
 (941)764-5858  
 Fax:(941)639-3861

NAME: \_\_\_\_\_

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

I authorize Dr. \_\_\_\_\_ to: ( ) obtain records from ( ) Send/ Release records to

NAME OF HOSPITAL/DOCTOR/SELF: \_\_\_\_\_

\_\_\_\_\_ CITY STATE ZIP CODE

\_\_\_\_\_ PHONE NUMBER FAX NUMBER

Continued Medical Care  New Patient

**MOST RECENT RECORDS NEEDED:** Office Visit EKG report Operative report

Stress Test X-Ray Report Echo Report Other: \_\_\_\_\_

(Give 3-5- Business days for Medical Release)

I understand that my records may contain information about alcohol and/ or drug treatment, mental health or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above. I also understand that this consent will expire six (6) months after the date below, or when the information requested with this consent has been received/ released. A photocopy of this release shall have the same effect as the original.

\_\_\_\_\_  
Patient signature/ Legal Representative (relationship) Date

Office use only: Mailed \_\_\_\_\_ Faxed \_\_\_\_\_ Pick up in person \_\_\_\_\_