Charlotte Heart & Vascular Institute

Mario J. Lopez, M.D., FACC
Terence P. Connelly, M.D., FACC
Sergio F. Cossu, M.D., FACC, FHRS
Ricardo R. Martinez, M.D.,FACC
David Hotchkiss, M.D., FACC

Michael A. Malone, D.O., FACC
Aneley Hundae, M.D., FACC
Agustin Collado, M.D., FACC
J. Robert Kuhns, M.D., FACC

Kristin Garcia-Miller AG, ACNP-BC
Andrew Obermeier, P.A.-C
Justina Raimer, P.A.-C
Robert Henning, P.A.-C
Dianne Baldwin, ARNP
Kholoud Ajib P.A-C

Dear ____,

We are glad that you have chosen The Arrhythmia Center @ Charlotte Heart & Vascular Institute for your Electrophysiology (EP) needs. We have scheduled your appointment with us on

____.

Dr. Sergio F. Cossu is Board certified in Internal medicine, Cardiovascular Disease and Cardiac Electrophysiology. He received his medical degree from Medical College of Wisconsin and has been in practice for more than 20 years. His specialty of Electrophysiology includes diagnosis and management of abnormal heart rhythms, implantation of pacemaker and Cardioverter Defibrillators with complete follow up care, and highly recognized for his extensive success with cyro ablations.

If you are a "self-referral", the doctor will need all your EP records BEFORE your appointment. Reviewing your records in advance will allow us to notify you for any further information we may need, which assures that duplicate testing will not be ordered and rescheduling of your appointment will not be necessary. Also in effort to decrease the time you spend in our waiting room, we have assembled a questionnaire for you to fill out in your home at your convenience. The information requested in the enclosed form is essential in understanding your personal medical history and will allow us to give you the best medical care possible. It is therefore very important that you please take the time to fill out the questionnaire. **Please remember to bring the completed forms with you the day of your <u>initial</u> office visit.** We greatly appreciate your cooperation and look forward to taking care of you and all of your heart and vascular needs.

If you do not have an EP diagnosis, and feel this appointment has been made in error, please call our office at 941-764-5858 ext#2319 or #2249 and we would be happy to reschedule you with the appropriate Doctor in our practice for your cardiac symptoms.

Sincerely,

Dr. Sergio F. Cossu, FACC

Port Charlotte· 3340 Tamiami Trail, Port Charlotte, FL 33952· 941-764-5858· Fax 941-764-1657
Central Park· 4161 Tamiami Trail, Suite 701, Port Charlotte, FL 33952· 941-629-5356· Fax 941-629-4987
Punta Gorda· 25097 Olympia Avenue, Suite 102, Punta Gorda, FL 33950· 941-235-7100· Fax 941-639-3805

Charlotte Heart & Vascular Institute

The Arrhythmia Center

Health Questionnaire
(Please Print)

Date of Birth:_______________ Soc. Sec #:_____- _____- _____ Appt. Date:__________

Name:____

Home Address:____
Street City State Zip

Age:______________________ Referred By:____

Briefly explain in your own words the problems which caused you to consult a physician today:

PAST MEDICAL HISTORY

Please list any and all medical problems ____
____
____
____

Do you currently have or suffer from:

Hypertension	YES	NO
Diabetes	YES	NO
Stroke	YES	NO
High Cholesterol	YES	NO
Arrhythmia	YES	NO
Fainting	YES	NO

Have you ever had any of the following operations? (Give dates)

Tonsillectony	YES	NO	Date:
Appendectomy	YES	NO	Date:
Remove of gallbladder	YES	NO	Date:
Hysterectomy (removal of female organ)	YES	NO	Date:
Hernia Repair	YES	NO	Date:
Hemorrhoidectomy	YES	NO	Date:

Other:____
____

Have you been hospitalized for any other reason? YES NO (If yes explain and give dates)
____
____
____

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Please list all your medications name, doses and freqency on space provided below:______________
____
____
____

Are you allergic to any medications? YES NO

If "yes" please list:____
Or attach your med sheet:____

FAMILY HISTORY

Parent	Age	#Living	#Deceased	Age at death	Condition or Illness
Mother:	_______	_______	_______	_______	____________________________
Father:	_______	_______	_______	_______	____________________________
Brother:	_______	_______	_______	_______	____________________________
Sister:	_______	_______	_______	_______	____________________________
Children:	_______	_______	_______	_______	____________________________
Spouse:	_______	_______	_______	_______	____________________________

Have any of your relatives (parents, brothers, sisters, or children) had any of the following? (Circle below)

Heart Trouble	YES	NO
High blood pressure	YES	NO
Stroke	YES	NO
Anemia	YES	NO
Diabetes	YES	NO
Cancer	YES	NO
Bleeding disorders	YES	NO
Tuberculosis	YES	NO

SOCIAL HISTORY (Circle below)

Marital Status: Single Married Divorced Widowed
Do you drink alcohol? YES NO
Do you smoke? YES NO
Do you drive? YES NO
Are you retired? YES NO
Previous employment: ____

REVIEW OF SYSTEMS (Circle below)

How do you feel in general? Excellent Good Fair Poor
Have you been able to perform your routine activities? YES NO
Has there been a change in your appetite? YES NO
Have you gained or lost more than five punds in the last year? YES NO
Have you had any recent chills, fever or night sweats? YES NO

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HEAD, EYE, EARS

Question		
Are you troubled by unusual or severe headaches?	YES	NO
Have you had any serious head injuries?	YES	NO
Has there been any history of loss of consciousness or seizures (convulsions or epilepsy)?	YES	NO
Have you had any problems with coordination?	YES	NO
Do you wear glasses or contact lenses?	YES	NO
Are you troubled by blurred or doubled vision?	YES	NO
Have you experienced excessive watering of the eyes or have your eyes felt itchy or painful?	YES	NO
Have you been told that you have glaucoma?	YES	NO
Do you have trouble hearing normal conversations?	YES	NO
Do you have a ringing or buzzing in your ears?	YES	NO
Have you had any ear problems in the past such as recurrent infections, swimmers' ear, ruptured ear drum or discharge from the ear?	YES	NO

RESPIRATORY

Question		
Do you have any allergies (for instance hay fever)?	YES	NO
Do you have sinus trouble?	YES	NO
Do you have nose bleeds?	YES	NO
Do you have more than three cold or sore throats a year?	YES	NO
Have you had any disorders of speech, tongue or swallowing?	YES	NO
Have you had any chronic or prolonged cough?	YES	NO
Have you ever coughed up blood?	YES	NO
Have you ever had asthma or do you wheeze?	YES	NO
Have you ever had pneumonia?	YES	NO
Have you ever had tuberculosis or a positive skin test for tuberculosis?	YES	NO

CARDIAC

Question		
Do you have any known heart disease?	YES	NO
Have you ever been told that you have high blood pressure?	YES	NO
Have you ever had any chest discomfort?	YES	NO
Have you ever had a heart attack?	YES	NO
Do you become short of breath easily?	YES	NO
Do you have to sleep with your head elevated on several pillows due to shortness of breath?	YES	NO
Do you ever wake from a sleep with marked shortness of breath?	YES	NO
Do you ever feel your heart racing or pounding for no apparent reason?	YES	NO

GASTRO-INTESTINAL

Question		
Do you have frequent heartburn or indigestion?	YES	NO
Has there been any recent nausea or vomiting?	YES	NO
Have you had recent abdominal pain?	YES	NO
Do you have any history of stomach or duodenal ulcer?	YES	NO
Have you ever had yellow jaundice or hepatitis?	YES	NO
Have you noticed any changes in your bowel habits?	YES	NO
Are your stools ever black in color?	YES	NO
Do you have bright red blood or pain with bowel movements?	YES	NO

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GENTRO-URINARY		
Is there any history of bladder or kidney infection?	YES	NO
Have you had any burning with urination?	YES	NO
Do you have to urinate more frequently than what is normal?	YES	NO
Do you feel an urgency to urinate?	YES	NO
Have you ever seen blood in your urine?	YES	NO
Do you have difficulty starting urination?	YES	NO
Do you ever feel like you are unable to completely empty your bladder?	YES	NO
Do you awake at night to urinate?	YES	NO

ENDOCRINE		
Does heat or cold appear to bother, you one more than the other? Specify which one.__________________	YES	NO
Do you have any history of thyroid problems or of being on thyroid medication?	YES	NO
Do you have excessive thirst?	YES	NO
Have you ever been told you have diabetes?	YES	NO

BLOOD		
Have you been told that you are Anemic?	YES	NO
Have you ever required transfusion?	YES	NO
Do you feel you bleed easily?	YES	NO
Have you recently noted swollen lymph nodes?	YES	NO

MUSCULO-SKELETAL		
Have you had any fracture or broken bones?	YES	NO
If yes please list:____		
Are you troubled by low back pain or back strain?	YES	NO
Is there any history of pain, stiffness, or swelling of joints?	YES	NO
Have you ever had swelling or collection of fluid in the legs or ankles?	YES	NO

EMOTIONAL		
Do you constantly feel excessively fatigued?	YES	NO
Do you have difficulty sleeping?	YES	NO
Do you have crying spells?	YES	NO
Are you troubled by nervousness, anxiety, or tension?	YES	NO
Have you felt depressed?	YES	NO
Have you used any tranquilizers (Valium, Librium, etc.)?	YES	NO
Have you ever been hospitalized for an emotional disorder?	YES	NO
Are you under the care of a psychiatrist?	YES	NO

MENSTRUAL HISTORY (For Females Only)		
Have you ever had any complications during pregnancy?	YES	NO
Do you have regular menstrual periods?	YES	NO
Are your menstrual periods abnormal in anyway?	YES	NO
Do you have severe cramping?	YES	NO
Have you had any problems with vaginal discharge?	YES	NO

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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? **YES** **NO**

2. Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, belly, legs, or arms? **YES** **NO**
   If yes, dates: ______________________________

3. When you walk, do you experience aching, cramping, or pain in your legs, thighs or buttocks? **YES** **NO**

4. If you answered Yes to #3, when do you feel the pain:
   - ☐ After walking 1 block.
   - ☐ Climbing a flight of stairs.
   - ☐ After walking 100 yards.
   - Walking at increased speed.

5. If you answered Yes to #3, circle the area (s) of the body on the diagram below where you feel pain.

6. If you have pain, does the pain subside with rest? **YES** **NO**

7. Do your feet or toes bother you at night while lying in bed? **YES** **NO**
   Is discomfort relieved when they are dangled at the edge of the bed? **YES** **NO**

8. Do you have any painful sores or ulcers on legs or feet that do not heal? **YES** **NO**

9. Are your legs discolored or bluish? **YES** **NO**

10. Check all that apply:
    - I am a current smoker
    - I have a history of smoking
    - I have diabetes
    - I have a family history of diabetes
    - I have high cholesterol
    - I have a family history of high cholesterol
    - I have high blood pressure/ hypertension
    - I have a family history of high blood pressure/ hypertension
    - I have/ had coronary artery disease (CAD)/ heart attack
    - I have a family history of coronary artery disease/ heart attack
    - I have had a stroke/ mini-stroke/TIA
    - I have a family history of stroke/ mini-stroke/TIA

We love our patients

We are an innovative cardiology practice located in Port Charlotte and Punta Gorda, Florida. At CHVI we strive to offer our patients convenient, high-quality care. One of the ways we do this is by offering our patients online health services through our website.

These services include online appointment scheduling, access to medical records, medication renewals, and more. If you are currently a patient with our clinic and interested in signing up for these services, simply click on the Register link located on the website and follow the instructions to sign-up.

Charlotte Heart & Vascular Institute, P.A.

3340 Tamiami Trail
Port Charlotte, FL 33952
PH: 941-764-5858
FX: 941-764-1657

Charlotte Heart & Vascular Institute, P.A.

NOTICE OF PRIVACY PRACTICES

This Notice is Effective as of March 21st, 2016

To Our Patients

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information.

This notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for services rendered, or in order to support the business activities of the practice.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

- Appointment Reminders
- Treatment Information Disclosure to Department of Health and Human Services
- Health Oversight Activities
- Abuse or Neglect
- Legal Proceedings
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- Organ Donation
- Public Safety
- Workers' Compensation
- Business Associates
- Authorizations

Your Rights Regarding Your Medical Information

You have the following rights with respect to your medical information:

You may ask us to restrict certain uses and disclosures of your medical information. We may not always be able to agree to it, but if we do, we will honor it.

You have the right to receive communications from us in a confidential manner.

You may ask us to amend your medical information, though we may deny your request for specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information.

You have the right to receive an accounting of the disclosures of your medical information made by our practice during the last six years, except for treatment disclosures, payment or healthcare operations.

You have the right to complain to us and/or the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To file a formal complaint directly with us or if you would like further information regarding your rights or regarding the uses and disclosures of your medical information, please contact our CEO and Privacy Officer at the address and phone number found on this brochure.

Thank you

Contact Us

Charlotte Heart & Vascular Institute, P.A.
3340 Tamiami Trail
Port Charlotte, FL 33952

PH: 941-764-5858
FX: 941-764-1657

Visit us on the Web:
www.charlotteheartandvascular.com

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

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:

Balance Due	# of Months
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.

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.

____

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

____

Print name of Patient Date of birth Patient account #

Charlotte Heart & Vascular Institute

Medical Records Release

Mario J. Lopez, M.D. FACC
Terence P. Connelly, M.D. FACC
Kristin Garcia-Miller AG, ACNP-BC
Andrew Obermeier, P.A.-C
3340 Tamiami Trail
Port Charlotte, FL 33952
(941)764-5858
Fax:(941)764-1657

Sergio F. Cossu, M.D., FACC, FHRS
Justina Raimer, P.A.-C
3340 Tamiami Trail
Port Charlotte, FL 33952
(941)764-5858
Fax: (941)613-1300

David Hotchkiss, M.D., FACC
Dianne Baldwin, ARNP
4161 Tamiami Trail, Suite 701
Port Charlotte, FL 33952
(941)629-5356
Fax(941)629-4987

Aneley Hundae, M.D., FACC
4161 Tamiami Trail, Suite 701
Port Charlotte, FL 33952
(941)629-5356
Fax:(941)629-5878

Ricardo R. Martinez, M.D., FACC
Robert Henning,P.A.-C
Michael A. Malone, D.O., FACC
25097 Olympia Avenue Suite 102
Punta Gorda, FL 33950
(941)764-5858
Fax: (941)639-3805

Cardiac Catheterization Lab
25097 Olympia Avenue, Suite 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_______________