Southshore Cardiovascular Associates
www.southshorecardio.org

New Patient Visit Questionnaire

Name:_____ Date of Birth: __/____/____

Home Phone #:_____ Cell Phone #:_____

Work Phone #:_____ Email Address:_____

Address:_____City: _____State:_____Zip:_____

Primary Care Physician:_____

Office Address:_____

Work #:_____ Fax #:_____

Referring Physician (if different):_____

Office Address:_____

Work #:_____ Fax #:_____

Pharmacy:_____

Address:_____

Phone #:_____ Fax #:_____

Will you need translation services during your visit? Yes: ☐ No: ☐

If yes, please list the language required: _____

*Please note: We **strongly recommend** an English-speaking family member accompany you to your visit.*

Why are you here to see a cardiologist today? Please be as specific as possible (e.g., symptoms or tests.)

_____

_____

_____

Do you currently smoke? Yes: ☐ No: ☐ Did you ever smoke? Yes: ☐ No: ☐

Did you ever use chewing tobacco or snuff?

Yes: ☐ No: ☐

(If yes to any question, please indicate type of tobacco, amount per day, number of years, and quit date.)

_____

Do you currently drink? Yes: ☐ No: ☐

(If yes, please indicate type(s) of alcohol and approximate number of drinks per week for each type.)

_____

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

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New Patient Visit Questionnaire

Do you currently work? Yes: ☐ No: ☐ Occupation:_____

Have you ever had major non-cardiac surgery before? Yes: ☐ No: ☐

If yes, please indicate **dates and types** of surgery:

_____

_____

_____

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New Patient Visit Questionnaire

PAST MEDICAL HISTORY:

Do **you** personally have a history of:

	YES	NO
Know coronary disease:		
"silent" heart attack (found incidentally):		
Heart attack(s) requiring hospitalization:		
Coronary artery stenting:		
Coronary artery ballooning only:		
Coronary artery bypass surgery:		
Heart rhythm disorders:		
Pacemaker: if so what type_____		
Defibrillator (ICD):		
Atrial fibrillation:		
Atrial Flutter:		
Ventricular arrhythmias:		
Cardioversion:		
Ablation Procedure:		
Heart Failaure:		
Heart Murmur:		
Mitral Valve prolapse:		
Rheumatic heart disease:		
High blood pressure (even if treated):		
High cholesterol (even if treated):		
Diabetes (even if treated):		
Stroke:		
Aortic aneurysm (enlarged aorta):		
Asthma/ Emphysema/COPD:		
Peripheral vascular disease:		
Gastrointestinal bleeding:		
Heartburn/ Reflex (GERD)		
Lung Cancer:		
Colon Cancer:		
Breast Cancer:		
History of blood clot (DVT/PE):		
Bleeding disorder:		
Thyroid disorder (hyper or hypo):		

Past Surgical History:

Do **you** personally have a history of:

	YES	NO
Heart valve repair:		
Heart valve replacement:		
Carotid artery surgery: (endarterectomy):		
Aortic Aneurysm repair/ stenting:		
Leg artery stenting or bypass:		

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New Patient Visit Questionnaire

Please indicate your family members' medical history as below:

	First Name	Alive? (Y/N)	Age	Heart Disease?	High Cholesterol?	Diabetes?	Stroke?	Cancer?	Emphysema or asthma?
Father									
Mother									
Brother(s)									
Sister(s)									
Son(s)									
Daughter(s)									
Other(s)									

For any family member you have indicated "yes" for heart disease above, please list the specific details below (e.g., heart attack, stents, bypass surgery, valve disease, congenital heart disease, atrial fibrillation, etc.) as well as the age of onset of the disease. If any family member died suddenly, please indicate the age at death and if the cause was heart-related (e.g., heart attack, sudden death, stroke, etc.)

Family member Age at onset/death Type of heart disease/Cause of death

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New Patient Visit Questionnaire

Do you have any ALLERGIES to medications? Yes: ☐ No: ☐

If yes, please list medications and reactions: _____

_____

Please list ALL of your CURRENT medications below (if you need more room please use back of page):

Medication (name)	**Amount**	**Frequency taken (daily, every 6 hours, etc.)**	**Approximate start date of medication**
Example: metoprolol	*25 mg*	*Once daily*	*2005*

Do you take any non-prescription medications? Yes: ☐ No: ☐

If yes, please list below: _____

_____

_____

_____

_____

_____

_____

_____

Southshore Cardiovascular Associates
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ DOB: _____ SS: _____

Authorize to release my confidential information regarding my medical records to:

Southshore Cardiovascular Associates

425 S. Kings Ave.
Brandon, Florida
33511
Ph. 813- 661-6199
813-661-6334 -FAX

13127 Vail Ridge
Dr. Riverview,
Florida 33579
Ph. 813-677-9200
813-677-9224- FAX

14525 Bruce B Downs
Blvd Tampa, Florida
33617
Ph. 813-988-2754

4051 Upper Creek Dr. unit
110
Sun City, FL. 33573
Ph. 813-358- 7200

Please send **ALL** records on patient to include: Cardiac Cath, EKG tracing, H&P, Discharge notes, Cardiac consult note, Labs, ECHO, Nuclear Stress Test, Operative Reports, CTA's, Arterial Doppler, Carotid Doppler, Dr. Singh's consult, Office notes, and ER reports.

Comments:

_____

_____

_____

_____

_____ _____

Patient Signature Date

Southshore Cardiovascular Associates

Informed Consent for Medical Examination and Treatment

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance conduct physical examination as necessary for my medical care. I acknowledge and consent to the following:

1. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, nurse practitioners, or other healthcare professionals. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

2. I understand that physical examination and evaluation of the heart may require exposure and touching of my chest, breast and groin areas at times. I also authorize nurses and technicians to attach EKG, Stress Test leads and Ultra Sound probe to all required areas including breast and chest areas as needed.

3. I understand that I can change my mind regarding the procedure or treatment. If I do, I must tell the person or the team doing the procedure or treatment *before* they start.

4. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

5. I understand that the clinic, as required by law, must report certain diseases to local and state agencies.

6. I understand that students and others may observe the procedure or treatment for educational purposes. Observers must be approved by this facility.

7. I also authorize nurses and technicians to attach EKG, Stress Test leads and Ultra Sound probe to all required areas including breast and chest areas as needed.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits). A copy of this document may be utilized the same as the original. I further acknowledge receipt of the Notice of Privacy Practices of Southshore Cardiovascular Associates at this visit or at a previous visit.

Patient Information

Printed Name_____**Date of Birth:**_____

Signature: _____ **Date: ___/___/____**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ DOB: _____ SS: _____
(Patient's Name)

Give: **Southshore Cardiovascular Associates**

425 S. Kings Ave Brandon, Florida 33511 Ph. 813- 661-6199 813-661-6334 -FAX

13127 Vail Ridge Dr. Riverview, Florida 33579 Ph. 813-677-9200 813-677-9224- FAX

14525 Bruce B Downs Blvd Tampa, Florida 33617 Ph. 813-813-988-2754 813-988-1001 - FAX

4051 Upper Creek Dr. #110 Sun City, FL. 33573 Ph. 813-358-7200 813-260-3672 - FAX

Authorization to release my confidential information regarding my medical records and health information to the following individuals/family members:

Name	D.O.B.	Phone#	Relationship

_____ _____
Patient Signature Date

_____ _____
Witness Date

IN CASE OF EMERGENCY

_____ _____ _____
name of local friend or relative (not living at same address) Home Phone No Relationship

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COVID-19 PATIENT SCREENING QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

1. **Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms?**

Fever or feeling feverish	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Shortness of breath or difficulty breathing	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
New loss of taste or smell	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Head or muscle aches	☐ Yes	☐ No
Nausea, diarrhea, vomiting	☐ Yes	☐ No

2. **In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?**
   ☐ Yes ☐ No

3. **In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?**
   ☐ Yes ☐ No

4. **Have you been tested for COVID-19?**
   ☐ Yes What was the result? _____
   Date you were tested _____
   ☐ No

5. **In the past 14 days, have you been on a commercial flight or traveled outside of the United States?**
   ☐ Yes ☐ No

6. **Do you have the following:**

Heart Disease	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Autoimmune Disorder	☐ Yes	☐ No

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

ATTENTION ALL PATIENTS

All co-pays are due at the time of your visit. If you do not have your co-pay you will have to reschedule the appointment to a later date.

All Appointments must be **cancelled** or **rescheduled** within 24 hours. Any same day changes to appointments or appointments that result in a "No Show" will accrue a mandatory $30.00 fee.

Please sign below stating that you are aware of the new Terms.

_____	_____
Print Name	Witness Name
_____	_____
Sign Name	Witness Signature
_____	_____
Date	Date

SOUTHSHORE CARDIOVASCULAR ASSOCIATES

NOTICE OF PRIVACY PRACTICES

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

If **you have any questions about this notice, please contact our Privacy Officer**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, ifrequired by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example. a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition. we may disclose your protected health information if we believe that you have been a victim of abuse. neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case. the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems. biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena. discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to. quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (l) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities. including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information. then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name. the location at which you are receiving care, your general condition (such as fair or stable). and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction

you wish to request with your physician. You may request a restriction by **[describe how patient may obtain a restriction.)**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer,at (813)661-6199 or **Info@southshorecardio.org** for further information about the complaint process.

SOUTHSHORE CARDIOVASCULAR ASSOCIATES

NOTICE OF PRIVACY PRACTICES

I have received, read, and understood the **NOTICE OF PRIVACY PRACTICES** for Southshore Cardiovascular Associates that have been provided for me by Southshore Cardiovascular Associates. I understand that if I have any questions I will contact the Privacy office regarding my concerns.

_____ _____

Patient Signature Date

_____

Witness