FLORIDA ELECTROPHYSIOLOGY ASSOCIATES®

Robert S. Fishel, MD, FACC
Faren R. Angella, MD, FACC
Vlad Rankovic, MD, FACC
Marcelo A. Jimenez, MD, FHRS
Matthew J. Kolek, MD, MSc
Jason M. Appelbaum, MD.
John Bibawy, MD.

Dear Patient,

We at Florida Electrophysiology Associates (FEPA) would like to take this opportunity to welcome you to our practice and thank you for choosing the most experienced practice with over 70 years practicing solely in Electrophysiology. FEPA is the largest EP program in the Southeast United States. We combine the latest technology, most skilled technique, and specialized expertise to our patients. We provide only the most advanced care and highest quality, treating our patients like family. We are grateful you choose us and will soon see why patients come to our practice for care from around Florida, the country and the world.

We have prepared this packet of information and patient forms in order to help make your first visit a convenient and pleasant experience. We ask that you please complete the attached paperwork prior to arrival.

When you come for your appointment, please bring the following:

- Completed patient Registration Form
- Signed Patient Privacy Form
- Completed patient History Form
- Signed patient No Show, Late Cancellation Policy
- Medical Insurance Cards. If no card is submitted at the time of your appointment you may be Asked to pay privately or reschedule your appointment.
- A complete printed list of all medications, vitamins, minerals, supplements and herbs including the strength and dosages.
- Written referral from Primary Care Physician, if required by your insurance.
- Previous x-rays, ultrasounds, CAT scans, laboratory test and medical records related to this Condition from your Primary Care Physician or Cardiologist.
- Photo ID will be required at the time of check-in in order to protect you from identity theft.

Please be prepared to pay for the following at the time of your visit:

- Co-payment (we would appreciate the exact $ amount due to the fact that the office does not Carry an excess amount of change) **Our office accepts cash, checks, VISA or Mastercard for The copayment.**
- If you do not have insurance, please call our office manager at (561)434-0353 ext 4 and we will Give you an estimate of what the cost of the visit will be. Payment is expected at the time of Service.

A NOTE ABOUT REFERRALS: You cannot assume that your referral has been approved unless you have received confirmation from your insurance company. Please call your Primary Care Physician to make sure that the referral has been accomplished prior to your appointment. Our staff is here to help you in whatever manner we can. If you have any questions please feel free to give us a call prior to your appointment.
If you bring your completed paperwork with you please check in 15minutes prior to your scheduled appointment time to allow our office to complete the administrative portion of your appointment and have your chart ready for the appointment. If you do not bring paperwork please arrive 30 minutes prior to appointment time.

If you are visiting us from out of town, we have an out of town directory we put together with JFK hospital to help with Lodging and Dining during your stay in our area. The directory is located on our website "heartbeatdoctor.com" under patient forms , then out of town patients. (Note: you will also receive one in your packet if you are scheduled for a procedure.) If there is anything we can do to assist you while you are visiting us, please feel free to let us know.

If you did not receive this letter on our website, please check us out at "heartbeatdoctor.com" for more information about all doctors, procedures, forms and office information.

Thank you again and remember, we are here with you every beat of the way.

The Florida Electrophysiology Associates family

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NEW PATIENT INFORMATION FORM

REFERRING DOCTOR_____ CONTACT PERSON_____

TELEPHONE #_____ FAX# _____

PATIENT INFORMATION

NAME_____

ADDRESS_____

HOME NUMBER_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____-_____-_____

DIAGNOSIS_____

INSURANCE INFORMATION HMO PPO OPEN ACCESS

PRIMARY_____

ID #_____ (SELF___ SPOUSE____ OTHER___) GROUP_____

PHONE #_____

SECONDARY_____

ID #_____(SELF__ SPOUSE____ OTHER__) GROUP_____

EXISTING DEVICE

MEDTRONIC_____ ST JUDE_____BOSTON SCIENTIFIC_____ BIOTRONIK_____ SORIN/ELA_____

HOSPITALIZED: YES/NO FACILITY_____

MEDICAL RECORDS NEEDED FOR APPOINTMENTS ARE (OFFICE NOTES, HOLTERHONITOR, EKG, ECHOCARDIOGRAM, STRESS TEST, ANY CARDIAC PROCEDURES RENDERED TO PATIENT)

PATIENT MUST BRING REFERRAL OR APPOINTMENT WILL BE RESCHEDULED

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MEDICATION LOG

DATE_____

PATIENT NAME_____

DATE OF BIRTH_____ PHONE NUMBER_____

PHARMACY NAME/NUMBER_____

*********ALLERGIES****** _____

MEDICATIONS	DOSAGE	QUANITITY	FREQUENCY

EMAIL ADDRESS_____

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Patients First Name:_____ Last Name_____
Street Address_____ City_____ State/Zip_____
Phone (___)_____Emergency Phone(____)_____
Marital Status◉Married◯Divorced◯Single◯Widowed SSN_____
Primary Provider_____ Referring Physician_____
**Preferred language:◉English◯Spanish◯French◯Other_____
Ethnicity:◉ Hispanic◯Non Hispanic◯Other _____ Race_____
Information requested on Ethnicity/Race/Language to meet Federal Meaningful Use Critera.*

Employer Information
Employers Name:_____
Employers Address:_____
_____
Employers Phone No: (____)_____
Occupation_____
Former Occupation if retired

Primary Insurance Provider Information
Primary Insurance Carrier_____
Group No_____ Policy No_____
Relationship to Subscriber_____(If relationship is SELF, Do not fill in subscribers information)
Subscribers First Name_____ Last Name_____
Subscribers Address_____
City_____ State/Zip_____
Subscribers Phone No._____
Subscribers DOB_____ Sex◯Male◯Female
Subscribers SSN_____
Copy/Deductible_____

Secondary Insurance Provider Information
Secondary Insurance_____
Group No_____ Policy No_____
Relationship to Subscriber_____(If relationship is SELF, do not fill in subscribers information)
Subscribers First Name_____ Last Name_____
Subscribers Address_____
City_____ State/Zip_____
Subscribers Phone No._____
Subscribers DOB_____ Sex◯Male◯Female
Subscribers SSN_____ Copay/deductible_____

How did you hear about us?
◯Website ◯Newspaper ◯Referred by Physician ◯ Friend ◯Other _____

Florida's leaders in the treatment of Cardiac arrhythmia's

180 JFK Drive, Ste 311 • Atlantis, FL 33462
Phone 561.434.0353 Fax 561.357.0869 Toll Free 888.VTACH.MD heartbeatdoctor.com

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Patient Medical History Questionnaire

Name:_____

Do you have any of these medical problems?

☐ Diabetes ☐ High Blood Pressure ☐ Prior Heart Attack ☐ Stroke

☐ Angina (chest pain) ☐ Ulcer ☐ Bleeding Disorder ☐ Kidney Disease

☐ Liver Disease ☐ Thyroid Disorder ☐ Cancer ☐ Lung Problems

Other:_____

Surgery

☐ CABG (Coronary Bypass) ☐ Valve Replacement ☐ Defibrillator

☐ Pacemaker ☐ Gall Bladder ☐ Tonsillectomy ☐ Appendectomy ☐ Hernia

Other:_____

Please list your Height:_____ Feet _____Inches and your Weight: _____Pounds

Drug allergies and reactions:_____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Have you smoked: ◯ No ◯ Yes Packs/Day____ # Years _____ If you quit, When?_____

Alcohol Intake: ◯ No ◯ Yes Typical amount and frequency_____

Recreational Drug use ◯ No ◯ Yes _____

Family History:

Father Alive, age____ or Deceased at age _____ From:_____

Mother Alive, age ____ or Deceased at age _____ From:_____

# of Brothers and any illness_____

# of Sisters and any illness_____

and ages of Children and any illnesses_____

Is there a family history of :

☐ Heart Attack ☐ Bypass Surgery ☐ Cardiac Arrest

☐ Serious Rhythm Problems ☐ Unexplained Fainting

Please Check All that Apply:

General

- ☐ Fevers
- ☐ Chills, Shakes
- ☐ Rashes
- ☐ Swollen Glands
- ☐ Frequent Itchiness
- ☐ Significant Intolerance to Heat/Cold

Eyes

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Cataracts
- ☐ Glaucoma

Ears

- ☐ Diminished Hearing
- ☐ Tinnitus (Ringing, Buzzing)
- ☐ Deafness

Mouth

- ☐ Poor Dentition
- ☐ Dentures
- ☐ Gum Bleeding

Cardiac

- ☐ Chest Pains
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Dizzy Spells
- ☐ Fainting Spells
- ☐ Wake Up Gasping for Air

Lungs

- ☐ Cough
- ☐ Wheezing
- ☐ Pain with Deep Breathing

Gastrointestional

- ☐ Nausea
- ☐ Vomiting
- ☐ Bright Blood in Stool
- ☐ Black / Very Dark Stool
- ☐ Poor Appetite
- ☐ Constipation
- ☐ Significant Weight Loss
- ☐ Acid Reflux

Neurologic

- ☐ Significant Memory Loss
- ☐ Arm or Leg Weakness
- ☐ Unsteady Gait (Walking)
- ☐ Speech Difficulty
- ☐ Visual Disturbances

Urologic

- ☐ Burning on Urination
- ☐ Blood in Urine
- ☐ Very Frequent Urination

Joints

- ☐ Swelling
- ☐ Stiffness
- ☐ Unusual Warmth

Mental Health

- ☐ History of Major Depression
- ☐ Severe Anxiety

Extremities

- ☐ Leg pain while Walking
- ☐ Varicose Veins
- ☐ Swelling

Skin

☐ Rashes ☐ Bruises ☐ Moles

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HIPAA RELEASE FORM

Name_____ Date of Birth _____/_____/_____

We may release your health information, including information about your condition, to a family member or friend who may be involved in your medical care or who helps you pay for your care. As described in our Notice of Privacy Practices, you have the right to request that we do not release your health information to certain individuals.

Please use the form below to indicate with whom we may release your health information to, notify or assist in the notification of a family member or friend who may be involved in your care.

Release of information

I authorize the release of information including the diagnosis, records, examination rendered to be and claims information. This information may be released to :

Spouse:_____

Child(ren):_____

Other:_____

This HIPAA release will remain in effect until terminated by me in writing. **When leaving a message:**

Please call my home____ work_____ cell_____ Number:_____

If unable to reach me:

You may leave a detailed message_____

You may leave a message asking me to return your call_____

The best day to reach me is _____ between_____:_____ and _____:_____

Signed:_____Date_____/_____/_____

Witness_____ Date____/_____/_____

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Records Release Form

To:_____

_____

_____

Re:_____

_____

_____

D.O.B._____

Dear Doctor:

Please be so kind as to send the following records on the above patient:

____ All records: Cardiac catheterizations, holter and/or event monitor reports with strips, most recent EKG, any pacemaker/defibrillator information, ECHO reports, Stress test: two parts, most recent office note.

____Other:_____

Please fax this page back with records.

Thanks for your help.

Any medical records pertaining to me may be sent to Florida Electrophysiology Associates, PA at the above below.

Signed_____

Date_____

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Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery

1. **Cancellation/No show policy for doctor appointments**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel and appointment, you may be preventing another patient from getting the much needed treatment they need. Conversely, the situation may arise where another patient fails to canel and we are unable to schedule you for a visit, due to a seemingly "full schedule".
If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty-five ($35.) fee; this will not be covered by your insurance company.

1. **Account Balances**

We will require that patients with self-pay balances due, pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bill or who would like to discuss a payment plan option may call and ask to speak with the office manager with whom they can review their account and concerns.

Patients with balances over one hundred dollars ($100.) must make payment arrangements prior to future appointments being made.

Print patient name:_____ signature:_____

Date:_____
Patient account# (office use only)_____