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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.

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**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.

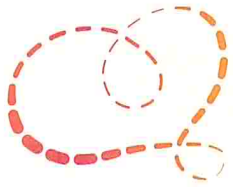
If you bring your completed paperwork with you please check in 15 minutes prior to your scheduled appointment time to allow our office to complete the administrative portion of your appointment and have your chart ready for the appointment. If you do not bring paperwork please arrive 30 minutes prior 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](http://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](http://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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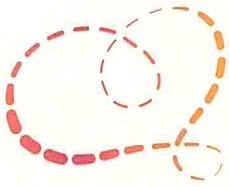
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**MEDICATION LOG**

DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

PHARMACY NAME/NUMBER \_\_\_\_\_

\*\*\*\*\*ALLERGIES\*\*\*\*\* \_\_\_\_\_

MEDICATIONS	DOSAGE	QUANTITY	FREQUENCY

EMAIL ADDRESS \_\_\_\_\_

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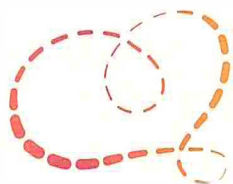
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Patients First Name: \_\_\_\_\_ Last Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_ Emergency Phone(\_\_\_\_) \_\_\_\_\_  
 Marital Status  Married  Divorced  Single  Widowed SSN \_\_\_\_\_  
 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 Criteria.\*

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**How did you hear about us?**  
 Website  Newspaper  Referred by Physician  Friend  Other \_\_\_\_\_

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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

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- 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

**Gastrointestinal**

- 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 cancel 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) \_\_\_\_\_

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