Florida Cardiopulmonary Center
Central Florida Cardiovascular Consultants, PL

Florida Amputation Prevention Institute

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PATIENT REGISTRATION

Patient
Full Name: _____ Age: _____ DOB: _____ Sex: _____

Mailing
Address: _____ City: _____ State: _____ Zip: _____

Physical
Address: _____ City: _____ State: _____ Zip: _____

(IF P.O BOX IS LISTED ABOVE)

Social Security
Number: _____ Home #: _____ Cell: _____

Patient Employer: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Insurance Information
Primary
Insurance: _____ Policy #: _____ Group #: _____

Primary Card
Holders Name: _____ DOB: _____ Social Security #: _____

Secondary
Insurance: _____ Policy #: _____ Group #: _____

Secondary Card
Holders Name: _____ DOB: _____ Social Security #: _____

Florida Cardiopulmonary Center
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HIPAA

Consent to the use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I_____, understand that as part of my healthcare, Florida Cardio Pulmonary Center originates and maintains paper and/or electronic records describing my history symptoms, examinations and test results, diagnosis, treatment and any future care or treatment.
I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that **Florida Cardiopulmonary Center** reserves the right to change their notice and practices and prior to implantation, in accordance with Section 164.520 of the code of Federal Regulations. Should **Florida Cardiopulmonary Center** change their notice, they will send a copy of any revised notice to the address I have provided. (whether by U.S.P.S. or by e-mail if selected).

I wish to have the following restrictions to us or disclosure of my health information:

_____

I understand that as part of this organization treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to other entity, and I consent to such disclosure for these permitted uses, including via fax.

We ask all patients to show their insurance cards and drivers license so that we can make copies of them. All services are charged directly to the patient, and he/she remains responsible for the payment. However, we will file any paperwork necessary to assist in making collections from the insurance company you provided to us. By signing below, I fully understand and accept the terms of this consent.

I authorize the Physicians of Florida Cardiopulmonary Center render medical care to the above name patient. I acknowledge that all information listed above is true and correct. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize release of any medical information necessary to process as insurance claim on my behalf. This signed agreement will act as a valid facsimile of the original.

Patient's Signature: _____ Date: _____
Office Use Only!

( ) Consent Received By: _____Date: _____