ASHCHI HEART & VASCULAR CENTER

PRIVACY PRACTICE-HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

You consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Print name: _____

Patient Signature: _____ **Date:** _____

3900 University Blvd S.

Jacksonville, FL 32216

904-222-6656 (P)

904-222-6657 (F)

ASHCHI HEART & VASCULAR CENTER

3900 UNIVERSITY BLVD. SOUTH
JACKSONVILLE, FL 32216
904-222-6656 (PHONE) 904-222-6657 (FAX)

PATIENT INFORMATION **Do you have an Advance Directive? Yes or No**

First Name: _____M.I. ____Last Name: _____

Home Address: _____ City: _____ State: _____

Zip Code: _____ Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Age: _____

Marital Status: Single Married Partnered Divorced Other

Email: _____SSN:_____

Patients Employer: _____ Occupation: _____

Work Number: _____Work Address: _____

Emergency Contact/Relation: _____Phone Number: _____

INSURANCE INFORMATION

Primary Policy Name: _____ID Number: _____

Group Number: _____ Primary Policy Holder: Self Spouse Parent

Primary Policy Holder's Name: _____ Date of Birth: _____

Secondary Policy Name: _____ ID Number: _____

Group Number: _____ Secondary Policy Holder: Self Spouse Parent

Secondary Policy Holder's Name: _____ Date of Birth: _____

Tertiary Policy Name: _____ID Number: _____

Group Number: _____ Tertiary Policy Holder: Self Spouse Parent

Tertiary Policy Holder's Name: _____ Date of Birth: _____

ACKNOWLEGDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge and agree that I have received a copy of Ashchi Heart and Vascular Center Notice of Privacy Practice.

Signature: _____ **Date:** _____

Print Name of Legal Representative and relationship: _____

Reason for today's visit? (Why are you here?):

_____

PATIENT HISTORY FORM

PATIENT CARE TEAM- List all doctors providing care

Doctor's Name	**Type of Doctor** (Primary Care, Urologist, etc.)	**Phone Number**	**Fax Number**

ALLERGIES **Do you have allergies to drugs, food, latex, dye? (Circle one)** **YES** **NO**

Allergy- list medication, food, latex, dye (contrast), etc.	Reaction- rash, shortness of breath, hives, itching, etc.	Severity (circle one)
		HIGH MODERATE LOW
		HIGH MODERATE LOW
		HIGH MODERATE LOW
		HIGH MODERATE LOW

MEDICATIONS **Please list all prescription medications, over-the-counter medications, and vitamins. (Bring in medication bottles for further clarity)**

Medication Name (full name from bottle)	**Dosage/Strength** (mg, mcg, ml etc.)	**How often do you take it?** (Daily, twice daily, etc.)	**How long have you taken?** (1 month, 2 years, etc.)	**Prescribing Doctor?**

MEDICAL HISTORY

Please check to the right of each item	YES	NO	DON'T KNOW	Please check to the right of each item	YES	NO	DON'T KNOW
Asthma/COPD/Emphysema				Kidney Artery Angio/Stent			
Aneurysm				Kidney Failure			
Artery Clot				Kidney Stone			
AFIB / Aflutter				History of STENT placement? Type:			
Blood or Clotting disorder				Liver Disease			
Bronchitis / Emphysema				Lung Clot			
Cancer Type:_____				Narcolepsy / Sleep Apnea			
Chest Pain / Angina				GERD/Peptic Ulcer			
CHF				Peripheral Vascular/Artery Disease			
CAD				Prostate Disease			
Diabetes How long?				Rheumatic fever			
Gallbladder				Seizures			
Heart Attack (MI)				Shortness of Breath			
Hepatitis				Thyroid Disease			
Hypertension				Stroke / CVA			
HIV /AIDS/ Hepatitis				Valvular Heart Disease			
High Cholesterol							

PAST SURGERIES AND PROCEDURES

Past Surgeries/ Procedures	YES	NO	DON'T KNOW	Past Surgeries/ Procedures	YES	NO	DON'T KNOW
Ankle /Foot / Hand Surgery				AICD/ DEFIB / Pacemaker Implant / ICD Lead Extraction			
Appendectomy				Aortic Aneurysm Repair			
Back / Neck Surgery				Cardiac Catheterization			
Breast Implant/ Reduction				Cardiomyoplasty			
Cataract				Cardioversion/RF Ablation			
Gallbladder				Coronary Angioplasty			
Gastric Bypass / Lap Band				Coronary Artery Bypass			
Hernia Surgery / Repair				Coronary Revascularization			
Hip Surgery / Repair				Heart / Organ Transplant			
Hysterectomy-Whole or Partial				Heart Valve Surgery / Repair			
Intestinal				Homograft Replacement			
Knee Surgery / Replacement				Prostate			
Sleep Apnea Surgery				Tonsils/ Adenoids			

SOCIAL HISTORY

Alcohol Use: YES NO

Do you consume alcohol?

Average number per week:

_____ beer _____ wine _____ liquor

Smoking/Tobacco Use:

YES NO Do you smoke or use tobacco?

YES NO Do you use e-cigarettes/vape?

YES NO Have you smoked in the past?

_____ Number of years? _____Packs per day?
_____Year quit?

Diet:

YES NO Are you on a special diet?

What type of diet? _____

YES NO Do you drink caffeinated beverages?

(Coffee, tea, cola, etc.)

How many daily? _____

Exercise: YES NO

Do you exercise on a regular basis?

(Minimum 30 minutes/3 times a week)

Substance Abuse: YES NO

Do you have history of drug dependency?

If yes, specify: _____

Occupation:

_____

____ Retired ____ Unemployed ____ Student

Residence (patient lives…)(check one):

____ Alone **____** w/children
____w/parents **____**w/spouse **____** w/spouse & children
____w/male partner **____** w/female partner
____ in nursing home **____**assisted living facility

Family History:

Mother: _____Alive ____Deceased? At what age_____

Father: _____Alive ____Deceased? At what age_____

Siblings: _____ # Brothers ____#Sister

_____# Alive _____# Deceased- Brother _____ #Alive _____# Deceased-Sister

_____# Alive _____# Deceased- Brother _____#Alive _____# Deceased Sister

_____# Alive _____# Deceased Brother _____#Alive_____# Deceased Sister

Authorization for Release of PHI – Family/Friends/Associates

My signature below serves as authorization for the release of my PHI to and from my family members, friends and associates listed below. If no one is listed only the PATIENT can receive PHI. (Use separate Health Release Form for Providers/Institutions.)

Name	Relationship	Phone Number

Print Name: _____

Patient Signature: _____ **Date:** _____

******THERE WILL BE A $25.00 CHARGE FOR ALL INSURANCE /FMLA /DISABILITY PAPERWORK, AND HAVE 30 WORKING DAYS TO COMPLETE. MEDICAL RECORDS WILL HAVE A $25 FLAT FEE FOR ALL RECORDS RELEASE TO PATIENTS UPON SIGNING A RELEASE AND NO LONGER WITH AHV OFFICE.*****

**Our cardiovascular specialists have privileges at Baptist Medical Centers, Baptist South, Memorial Hospital Jacksonville, Orange Park Medical Center, Specialty Hospital, Brooks Rehabilitation Hospital, St. Vincent's Medical Center Southside and Flagler Hospital. If you or your family members are admitted to these hospitals, please ask the your nurse or administration for your doctor here at Ashchi Heart & Vascular Center so we may provide you with the continuous excellent care you always enjoyed with our group. We are on call for our patients 24/7 at these locations. Our group provides you with board certified cardiologists and vascular specialists in several First Coast area locations

3900
University Blvd. S
Jacksonville, FL
32216
Phone: 904.222.6656 Fax: 904.222.6657
DrAshchiHeart.com

MEDICAL RECORDS REQUEST

Patient: _____ DOB: _____ SSN:

_____ To: _____ Fax Number:

_____

The release of any information considered confidential under Florida Law, such as that regarding psychiatric, drug or alcohol abuse, HIV/AIDS testing, counseling, or treatment, or other sensitive materials which may or may not be in my medical records is:

☐ **AUTHORIZED** **OR** ☐ **UNAUTHORIZED**

This written request for release of medical records is valid for 12 months from the date of my signature unless revoked in writing by me or my authorized agent. I agree to hold both the sending and receiving parties to this request harmless from any and all costs, liability and damages of any nature resulting or indirectly from the release of my medical records.

Type of Medical Information Requested for Continuity of Care

- ◯ All Medical Records
- ◯ Laboratory Results
- ◯ EKG Tracings
- ◯ All Cardiac and Vascular Testing
- ◯ Cath Report
- ◯ CABG, Valve Surgery Report
- ◯ Tee Report
- ◯ Diagnostic Imaging, CT's/ MRI's
- ◯ EP/Vein Ablation
- ◯ Pacer/AICD Implant
- ◯ Holter/ Zio Patch/ CAM
- ◯ Other: _____

_____ _____

PATIENT'S SIGNATURE **DATE**

_____ _____

PRINTED NAME OF PATIENT **WITNESS**