CardiaCare Services, P.A.

Information Update

UPDATED YEARLY

Date: ______________________

Patient Name: ______________________

Current Address: ______________________

____

Date of Birth: ______________________

Primary Care Doctor: ______________________

Current Insurance: ______________________

Responsible Party: ______________________

Home Number: ______________________

Work Number: ______________________

Employer: ______________________

Signature: ______________________

PHARMACY INFORMATION

NAME OF PHARMACY ______________________

ADDRESS/INTERSECTION ______________________

____

PHONE NUMBER ______________________

SHIVANAND S. KARKAL, MD
Clinical & Interventional Cardiology

1850 Lee Rd., Ste. 200 • Winter Park, FL 32789
Phone: (407) 644-5544 • Fax: (407) 644-5440

1507 S. Hiawassee Rd., Ste. 109 • Orlando, FL 32835
Phone: (407) 644-5544 • Fax: (407) 294-0445

PATIENT QUESTIONNAIRE

1. Please list other family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, health care operations and medical records):

____
____
____

2. Please list members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: ____________________________ Phone Number: ________________________
Name: ____________________________ Phone Number: ________________________
Name: ____________________________ Phone Number: ________________________

3. Please print the address of where you would like your billing statement and/or correspondence from our office to be sent if other than your home:

____
____
____

4. Please print the telephone number where you want to receive calls about your appointments and/or other healthcare info if other than your home phone number.

____

I am fully aware that a cell phone is not a secure and private line.

Patient Signature ___________________________________ (guardian if under 18 years old)

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Acknowledgment Form

Our notice of Privacy practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing out practice or requesting a copy form our front desk staff.

You have the right to request that we restrict how protected health information about you is used or release for treatment, payment, or health care operations. We are not required to agree to these restrictions, but if we do we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made release in reliance on your prior consent.

Patient Name

Print ___________________________

Signature ___________________________

Date ___________________________

Witness ___________________________

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FAX: 407-294-0445 **PHONE: 407-644-5544**

CONFIDENTIAL

Authorization for release of Patient Health Information

Date of Request: ______________________

Patient Name: ___________________________________

Signature: ___________________________________
(Patient or Legal Guardian)

Date of Birth: ____________________ **SSN #:** _____________________

Phone Number: ____

- ❑ Echo
- ❑ Stress Test
- ❑ Cath Report
- ❑ Discharge Summary
- ❑ Chest X-ray/ CT/ MRI
- ❑ Other ________________

I herby authorize CardiaCare Services, P.A. to:

RELEASE/ OBTAIN

(Circle only one)

The protected health information regarding the above-named person to/from:

Person/Institution ______________________________________

Address ____
City State Zip

Phone _____________________________ Fax ________________________

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.