PRIMED
HealthCare P.A.
Providing All Your Health Care Needs.

Rafael Jimenez, M.D.
Cardiology

Please bring all enclosed paperwork completed to your scheduled office visit. Also, any cardiac testing, EKG's, bloodwork and referrals must be brought with you. Failure to bring this will result in the rescheduling of your appointment.

For your convenience, we accept **Mastercard, Visa, Money Orders or Cash. NO Checks** are accepted.

Thank you in advance for your cooperation.

302 W. Bass Street • Kissimmee, FL 34741 • (407) 518-7999 • Fax (407) 518-9766

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Date: _____ **Doctor:** _____

Patient Information Form

Please Print Mr. ___ Ms. ___ Mrs. ___ Miss ___ Dr. ___

Last Name: _____ First Name: _____ MI _____

Date of Birth _____ Age _____ Sex ____ Social Security # _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Alternate Contact Person & Phone Number _____

Mailing Address *(if different)* _____

Occupation _____ Employer _____ Phone _____

Spouse _____ Employer _____ Phone _____

Social Security # _____ D.O.B. _____

Responsible Party (if other than patient) _____ Address _____

Emergency Contact _____ Relationship _____ Phone _____

Your Pharmacy _____ Phone _____

Are you in a Nursing Home? _____ Facility Name _____

Primary Insurance _____ Group # _____ ID # _____

Policy Holder _____ Date of Birth _____ Relationship _____

Policy Holder Social Security # _____ (if other than patient) _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance _____ Group # _____ ID # _____

Policy Holder _____ Date of Birth _____ Relationship _____

Policy Holder Social Security # _____ (if other than patient) _____

Address _____ City _____ State _____ Zip _____

Below, please list the physicians with who we may share your health information. This authorization will continue for one year unless revoked.

Primary Care Physician/Family Physician _____

Referring Physician _____

Other Physicians Full Names _____ _____

_____ _____ _____

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient Representative Relationship to Patient

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Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

Name of Patient *(Please Print)* Date of Birth

Signature of Patient

Date of Signature

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please complete the following:

- May we leave messages concerning your **Appointments** with the person that regularly answers your calls? ☐ **Yes** ☐ **No** ☐ **N/A**
- May we leave **Messages** on a voice mail? ☐ **Yes** ☐ **No** ☐ **N/A**
- Please print the names of the Individuals with whom we may discuss your Medical History.

Name:	**Relationship:**

- ***You must inform us In Writing if you wish to change the manner in which this office communicates to you. Thank you.***

Please place in the patient's medical record.

Patient's Signature **Date**

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Side 1

Doctor: _____

MEDICAL HISTORY FORM

Name of Patient _____ Date of Visit: _____
Last First M.I.

Date of Birth _____ Age: _____ Sex: _____ Height: _____ Weight: _____ lbs.

What medical problem or condition are you here to have evaluated? _____

_____

List any other physician that is involved in your care. _____

Current Medications (please list all prescriptions, non-prescription medications and nutritional supplements)

CURRENT MEDICATIONS	DOSE (Strength)	SCHEDULE (How many & times per day)	HOW LONG HAVE YOU TAKEN?

Drug / Food Allergies

Are you allergic to:	Yes	No	Please list all allergies to medications and other substances. Describe reaction they cause.
Any Medications	☐	☐	_____
X-ray dye or IV contrast	☐	☐	_____
Can you tolerate aspirin?	☐	☐	_____

Social History

Do you have:	Yes	No
High blood pressure	☐	☐
Diabetes	☐	☐
High cholesterol	☐	☐
Family history of heart or vascular disease	☐	☐

Do you now or have ever smoked tobacco products? ..... ☐ ☐

Cigarettes # of packs per day: _____ # of years: _____

Do you:	Yes	No
Drink caffeine on a regular basis?	☐	☐
Drink alcohol on a regular basis? ..... ☐ Daily ☐ Weekly ☐ Monthly	☐	☐
Use recreational drugs?	☐	☐

MEDICAL HISTORY FORM
Side 2

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Doctor: _____

Activity level: which of the following describes your level of physical activity in your daily life and leisure time.

- ☐ Exercise strenuously on a regular basis
- ☐ Exercise moderately on a regular basis
- ☐ Exercise on an occasional basis
- ☐ Do not regularly exercise, but have an active lifestyle
- ☐ Have difficulty accomplishing light chores of daily living
- ☐ Require assistance to accomplish self-care

Have You Ever Had Any of the Following	Yes	No	Date or Year	Place (Hospital or City)	Complications / Problems
Exam by a Cardiologist (Heart Doctor)	☐	☐			
Heart Catheterization or Angiogram	☐	☐			
Coronary Angioplasty (PTCA/Ballon/Stents)	☐	☐			
Exercise Stress Test (Treadmill)	☐	☐			
Echocardiogram (Ultrasound of the Heart)	☐	☐			
Pacemaker/Defibrillator	☐	☐			
Open Heart Surgery	☐	☐			
Nuclear Study	☐	☐			
Holter / Event Monitor	☐	☐			

Previous Operations / Procedures	Year	Surgeon	Place (Hospital or City)	Complications / Problems

Reasons for other Hospitalizations (non Surgical Admissions)	Year	Physician	Complications / Problems

Please List any Other Illnesses or Chronic Conditions Not Listed	How Long Have You Had This

Family History

Relation	Age	Age at Death	Heart Attack	Sudden Death	Stroke	Aneurysm	Diabetes	Cancer	High Blood Pressure	High Cholesterol	Heart Failure
Father:											
Mother:											
Sister:											
Sister:											
Brother:											
Brother:											

Review of Symptoms

- ☐ Heart attack. What year(s): _____
- ☐ Chest discomfort / angina with physical activity.
- ☐ Chest discomfort / angina at rest.
- ☐ Shortness of breath with exertion.
- ☐ Shortness of breath at rest.
- ☐ Require more than one pillow at night to breath well.
- ☐ Heart Failure or “fluid on lungs”.
- ☐ Palpitations, racing or pounding heart beat.
- ☐ Pauses in the heart beat.
- ☐ Previously diagnosed heart rhythm disturbance.
- ☐ Heart murmur
- ☐ Mitral valve prolapse.

Payment Policy

Thank you for using PriMed Healthcare/Dr. Rafael Jimenez' office as your Cardiovascular healthcare provider. We are committed to providing you quality healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have decided to develop and put in place a payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **INSURANCE** : We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit and/or at the time services are rendered. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit or service rendered is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have.
2. **PROOF OF INSURANCE**: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
3. **CO-PAYMENTS AND DEDUCTIBLES**: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company**. Failure on our part to collect co-payment and deductibles from patients can be considered fraud**. Please help in upholding the law by paying your co-payment at each visit or at the time service is rendered. For your convenience we accept cash, MasterCard, VISA, and Discover.
4. **CLAIM SUBMISSION:** We will submit your claims and assist in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the allowable amount from your insurance company will be billed to you, the member, if you do not comply with their request and this balance will be your responsibility. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. **COVERAGE CHANGES:** If your insurance changes, please notify us before your next visit or service rendered so we can make the appropriate changes to help you receive your maximum benefits. Failure to provide us with any insurance change prior to or at the time of your visit will result in the allowable amount for services rendered billed to you the member and it will be your responsibility.
6. **PAYMENT PLAN:** Please let us know if you are having difficulty paying your account. We may be able to help you be setting up a payment plan based on your hardship. In this case, you will be asked to sign a promissory note. You are responsible to honor and keep the promissory note payments current.
7. **NONPAYMENT:** If your account is over 90 days past due and you failed to comply with any promissory note arrangements, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will be available to treat you in case of an emergency.

8. **MISSED APPOINTMENTS:** Our policy is to charge for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or cancelling with enough time to serve another patient's need.

Our practice is committed to providing the best treatment for our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of Patient or Responsible Party Date