PATIENT INFORMATION – PLEASE PRINT

***PLEASE GIVE YOUR INSURANCE CARD AND DRIVERS LICENSE TO THE RECEPTIONIST**

Last Name: _____ First Name: _____

Date of Birth: _____ SS#: _____ M F

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Primary Care/Family Doctor: _____

Pharmacy Name/Phone Number: _____

EMPLOYER INFORMATION:

Employer Name: _____

Employer Phone: _____ Occupation: _____

SPOUSE/FAMILY/PRIMARY CONTACT INFORMATION:

Last Name: _____ First Name: _____

Address: _____

City/State: _____ Zip Code: _____ Relation: _____

Home #: _____ Cell #: _____ Work #: _____

It is the policy of the office of Tampa Cardiovascular Associates, P.A. to release information to your immediate family and/or leave messages with them or on your answering machine regarding appointments, lab/test results, billing or any other information we feel is necessary to provide quality care for you. You must specify in writing if you do not agree with this policy.

I have read the above statement and the Notice of Privacy Practices and understand my rights.

Signature of Patient: kjk _____ **Date:** _____

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS: I hereby give consent to Tampa Cardiovascular Associates, P.A., and the staff to provide whatever treatment they may deem necessary to the patient above. I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy or Medicare. Should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all court costs, interest, collection costs, and attorney's fees.

I hereby request payment of authorized Medicare benefits and/or any other including supplemental insurance benefits for me to be paid directly to Tampa Cardiovascular Associates, P.A./Vasco M. Marques, M.D., P.A. for any services furnished me. I authorize Tampa Cardiovascular Associates, P.A., and staff to release to my insurance carrier and its agents any information concerning healthcare, advice, treatment or supplies provided me needed to determine these benefits payable for related services. I understand this is a lifetime authorization.

Signature of Patient: lk,jk _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & PERMISSION TO SHARE HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices of Tampa Cardiovascular Associates, P.A. this date. Yes ☐ No ☐

Signature of Patient: _____ Date: _____

AUTHORIZED REPRESENTATIVE (Title): _____

_____ Received but refused to sign:

STAFF SIGNATURE: _____ Date: _____

NOTIFICATION OF FAMILY AND FRIENDS

I hereby authorize Tampa Cardiovascular Associates, P.A. and staff to disclose my health information to the following persons (name, relationship, telephone number):

1. _____
2. _____
3. _____

Signature of Patient: _____ Date: _____

AUTHORIZED REPRESENTATIVE (Title): _____

RESTRICTIONS ON THE USE & DISCLOSURE OF MY HEALTH INFORMATION:

I understand that I may request certain restrictions on the use and disclosure of my health information. I request the following restrictions. The office of Tampa Cardiovascular Associates, P.A. is **NOT** required to agree to my requests:

1. _____

Signature of Patient: _____ Date: _____

AUTHORIZED REPRESENTATIVE (Title): _____

Please check One:

☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or other Pacific Island
☐ Black or African American
☐ White
☐ Hispanic
☐ Other Race
☐ Prefer not to answer

Please check one:

☐ Hispanic or Latin
☐ Not Hispanic or Latin
☐ Prefer not to answer

Preferred Language: _____