St. Augustine Cardiology Associates, P.A.
Ferris E. George, M.D. Robert N. Signor, M.D.
Billie J. Russell, PhD, ARNP-BC Susan W. Morrow, ARNP
201 Health Park Blvd., Suite 105 St Augustine, FL. 32086
904-824-1776

We welcome you as a patient

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care in the gentlest manner. The following information is designed to familiarize you with our office procedures. If you have questions please feel free to ask us. Our goal is to help you understand our office and how our staff can best serve you. Enclosed are our new patient forms, please fill them out and bring them to your office visit. If you have had any previous cardiac testing or recent lab work it is important to obtain these records prior to your scheduled visit. In addition to these forms please bring your insurance cards, picture ID and ALL medication (including any supplement you may be taking) to your appointment.

Office Hours

Monday – Friday 8:00 a.m. – 5:00 p.m.

Hours are by appointment. Due to the nature of our practice it is sometimes necessary to re-schedule appointments to accommodate unstable patients. We appreciate your understanding if your appointment is being re-scheduled. Kindly allow 24 hours notice of any cancellation. We reserve the right to charge a fee for any appointment cancelled without a 24 hour notice.

Telephone calls

All patients are encouraged to call with any questions they have concerning their cardiac problems. Our staff is trained to answer many of your questions. They also relay your information to the doctor and your call will be returned at the earliest opportunity. During office hours the physicians and nurses are occupied with caring for scheduled patients. Messages are reviewed around noon and again before 5 PM. Calls are answered according to urgency.

Prescriptions & Renewals

All prescriptions and authorizations for renewals should be requested through your pharmacy. Please follow your doctors recommendations regarding your medications and **do not stop medications** without the advice of your physician. Kindly allow **72** hours for all refills and written prescriptions. Due to the time involved we do not call mail order pharmacies, please plan accordingly. Most prescriptions are filled electronically, requesting a refill from your pharmacy is the most efficient way to get your medications refilled.

Financial Policy

The doctors and staff are committed to providing the best treatment for patients and we charge what is usual and customary for our area. Your clear understanding of our financial policy is important to our professional relationship. The following is a statement of our financial policy that we require you to read prior to treatment. Please ask if you have any questions regarding fees, financial policy, or your responsibility. You are responsible for the timely payment of your account. We accept Visa/ MasterCard/Discover, checks and cash. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate. **All co-pays and deductibles are due at the time of treatment**. Your insurance coverage is a contract between **you** and **your** insurance company. We are not party to that contract. We will help you receive maximum benefits and will file your claims for you. In the event that we accept assignment of benefits, the patient is still ultimately responsible for all charges. If your insurance company has not paid your account in full in 90 days, the balance is due in full from the patient or guarantor.

ST. AUGUSTINE CARDIOLOGY ASSOCIATES, PA

Ferris E. George, MD Robert N. Signor, MD
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To All Patients in Dr. George's Clinic

Due to the nature of the cardiology business, there are numerous emergencies that require Dr. George to be present. This makes it increasingly difficult for Dr. George to see all of his clinic patients personally. In order to assist him in treating and prioritizing medical issues in his practice, he uses Nurse Practitioners, who have received specialized cardiology training. Please be aware that very frequently patients in his practice will be seeing Billie or Susan for their follow up appointments. This is being done in the best effort to help minimize wait times and rescheduling of appointments. Please know that any acute medical issues will be brought *immediately* to the physician's attention.
We appreciate your understanding in this matter. If you have any special requests involving the above issues please bring it to the receptionists attention prior to your visit so that we may best try to accommodate you.

Thank you
St. Augustine Cardiology Associates

Signature:_____ Date:_____

Practice Limited to Diagnosing and Treatment of Cardiovascular Diseases
201 Health Park Blvd., Suite 105 ~ St Augustine, FL. 32086
(904) 824-1776

Revised 2/2017

St. Augustine Cardiology Associates

PATIENT INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex:**
City:	**Preferred Language:**
State: **Zip:**	**Email:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone**#:
Cell Phone#:	**Primary Care Physician**:

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security**#:
Address Two:	
City:	**Employer:**
State: **Zip**:	**Employer Address**:
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance**:
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**

PATIENT ADDITIONAL INFORMATION

Race:	Asian Native Hawaiian Other Pacific Islander Black or African American American Indian / Alaska Native White More than 1 race Unreported / Refused to Report
Please circle one :	
Ethnicity	Hispanic/ Latino Not Hispanic/ Latino Unreported/ Refused to Report

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider, St Augustine Cardiology when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, St. Augustine Cardiology to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) Date

St. Augustine Cardiology Assoc., P.A.

Ferris E. George, M.D. Robert N. Signor, M.D.
Billie J. Russell, PhD., ARNP-BC

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____
Date of Birth:_____

Please note: The accuracy of your medical record is one of our primary concerns! Please provide copies of any pertinent medical office notes, laboratory, or procedure reports prior to your appointment. Use a separate piece of paper if necessary. Thank you.

Main Complaint:_____

How long has this been occurring?_____
How often does this occur?_____
How long does this last?_____
Does anything make this worse?_____
Does anything make this better?_____

Do you experience any of the following? (Check all that apply)

___ Chest discomfort / pain
___ Shortness of breath
___ Swelling in your legs
___ Other:_____
___ Dizziness or lightheadedness
___ Irregular / Rapid / Forceful heartbeats
___ Fainting episodes or "Blacking out"

PAST MEDICAL HISTORY

Have you ever been diagnosed with/treated for any of the following conditions?

___ Heart attack
___ Coronary Artery Disease
___ Vascular Disease
___ Aneurysm
___ High blood pressure
___ High cholesterol
___ Diabetes
___ Stroke
___ Congestive heart failure
___ Heart valve disorder
___ Rheumatic or Scarlet Fever
___ Heart arrhythmia (irregular heartbeats)
___ Heartburn or Reflux disease?
___ Other heart disease/illness? Explain:_____
___ Lung disease/illness? Explain:_____
___ Kidney disease/illness? Explain: _____
___ Other disease/illness? Please list: _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR PROCEDURES?

	When	Where
___ EKG (electrocardiogram)	_____	_____
___ Stress Test (Treadmill or Chemical)	_____	_____
___ Heart Catheterization/Angiogram	_____	_____
___ Carotid Ultrasound/ Surgery	_____	_____
___ Abdominal Aorta Ultrasound	_____	_____
___ Other Angiogram	_____	_____
___ Angioplasty and/or Stent	_____	_____
___ Coronary Bypass Surgery (CABG)	_____	_____
___ Other bypass surgery	_____	_____
___ Echocardiogram (Cardiac Ultrasound)	_____	_____
___ Cardiac valve surgery	_____	_____
___ Pacemaker or defibrillator implantation	_____	_____

OTHER SURGERIES OR PROCEDURES (Please list)

FAMILY HISTORY (age, living or deceased, details regarding health):
Mother: _____
Father: _____
Brother(s): _____
Sister(s): _____
Children: _____

SOCIAL HISTORY:
Occupation (current, former, disabled): _____
Do you exercise regularly? If so, how much? _____
Do you drink alcohol? If so, how much? _____
Do you smoke? If so, how much? How long? _____
Former smoker? When did you quit and how much did you smoke? _____
Do you have a history of drug abuse?_____

DO YOU HAVE AN ALLERGY TO ANY SUBSTANCE OR MEDICATION? _____Latex? ____
Over the counter medications? ____ Environmental? _____ If yes, please list.

YOUR CURRENT MEDICATIONS (Please include ALL of them, with the dosage and frequency)

Do you take ANY herbal medicines, vitamins, dietary aids or supplements (please list)?

GENERAL HEALTH INFORMATION (Please answer yes or no, and provide details if appropriate):

_____ Do you have routine check-ups every year?
_____ Do you have your blood pressure checked regularly?
_____ Has your cholesterol level been checked?
_____ Have you had a recent chest x-ray?
_____ Have you had a recent colonoscopy? Year? _____
_____ Have you had a recent mammogram? Year? _____
_____ Have you had a recent Prostate Specific Antigen (PSA) test?
_____ Do you receive yearly flu vaccinations? Year?_____ Pneumonia Vaccine? Year?_____
_____ When was your last eye exam? Shingles Vaccine? Year? _____
_____ Any problems with weight gain or loss?
_____ Have you ever received a blood transfusion?
_____ Have you travelled outside of the United States in the past 12 months? If yes. Where? _____
Are there any other medical issues that were not covered on this form? If so please list:

Thank You!

him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF PRIVACY POLICIES

FOR

St Augustine Cardiology Assoc., PA
201 Health Park Blvd., Suite 105
St Augustine, Fl. 32086
(904) 824-1776

Effective 4-14-2003
Revised 2/2017

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At St Augustine Cardiology Assoc., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 4/14/2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit St Augustine Cardiology Assoc., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of St Augustine Cardiology Assoc, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

ST AUGUSTINE CARDIOLOGY ASSOC., PA is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Susan Romanelli at 904-824-1776

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions regarding this notice, please ask to speak with our HIPPA Compliance Officer in person or by phone at 904-824-1776.

Your signature below is only acknowledgment that you have received the pamphlet titled "Notice of Privacy Policies" for St. Augustine Cardiology Associates.

Print Name:_____

Signature:_____

Date:_____

Please list the persons that we are permitted to release information to. Unless you give us this permission we will be unable to talk to anyone, including family members, if they call our office regarding any health care information.

Name Relationship Phone #

_____

_____

_____

_____

_____

I have reviewed the above information and would like to make the following changes.
If there are no changes, please sign and date below.

Signature:_____ Date:_____

Name Relationship

_____

_____

Revised 2/2017

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T: (904) 824-1776 F: (904) 825-1270

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____ Date of Birth: _____

Current Address: _____

REQUESTING RECORDS FROM:
Doctor/Hospital/ Clinic Name: _____
Address: _____
Phone Number: _____ FAX Number: _____

I authorize the release of my medical information to:

St. Augustine Cardiology Associates, PA

SPECIFIC DOCUMENTS TO BE RELEASED:

- **( ) All records from specific dates: _____**
- **( ) Specific Records - Please list: _____**
- **( ) All cardiac diagnostics (example: stress testing, Holter monitor, Catheterization, ECHO ect)**
- **( ) OTHER: _____**

PURPOSE OF REQUEST ( ) Continuation of care ( ) Insurance ( ) Personal ( ) Legal

Please ( ) Mail - address above ATTN: Medical Records ( ) FAX – number above

This request is authorized to include any federal and/or state protection under Florida Statutes 394.459(9) Psychiatric information, 397.053/396.112. Drug and Alcohol abuse information, 381.609 HIV and AIDS related conditions 397.50(3) of minor client

NOTE TO REQUESTING PARTY: Florida Statue has established guidelines and cost rates for the copying of some records. Your signature on this form indicates your knowledge of this statement.

I hereby release _____; and its employees, agents officers, and affiliates, from any and all liability, responsibility, claim and damages which may result from the release of information authorized by this consent for release of information.
This request shall remain in effect for one year, unless otherwise specified.

SIGNED: _____ **DATE**: _____

If not patient, please state relationship:_____

WITNESS: _____ **DATE**: _____