

St. Augustine Cardiology Associates, P.A.
Ferris E. George Jr., M.D., F.A.C.C. **Robert N. Signor Jr., M.D., F.A.C.C.**
Billie J. Russell, PhD, APRN-BC **Madelyn Pellicer, APRN, FNP-C**

Date: _____

Dear _____,

Your appointment in Dr. George's clinic / Dr. Signor's Clinic is scheduled for

_____.

In order to make your visit a smooth experience, we are enclosing your new patient paperwork. Please fill out these forms and bring them with you to your office visit. **We only need the forms you filled out returned. If you have previous cardiac history/records, please fill out the records release form with the appropriate doctor/clinic and send to your previous doctor so we can get your records *prior* to your visit. If you need us to FAX this request to your clinic- PLEASE forward to us ASAP with the phone and FAX numbers so we can receive your records BEFORE your appointment.** If you are covered under your spouses insurance, please provide us with his/her date of birth. Also, please bring **all of your medications** and supplements, your insurance card and a photo I.D to your visit. All co-pays and deductibles are due at the time of your office visit. Our billing department will be happy to assist you if you have any questions regarding your insurance. **If you are unable to keep this appointment, kindly give us as much notice as possible, as we have limited new patient appointments and a long waiting list. Please arrive 15 minutes prior to your appointment time.**

Please provide us with a valid email address so we can send you an invite to connect to our patient portal. This will provide a more efficient way for you to communicate with our staff. It also allows you see lab/test results, office visits and upcoming appointments.

If you are not feeling well, we are asking that you reschedule your appointment. We are limiting the number of patients in our waiting room. If the waiting room is full, we have seating available immediately outside our office to wait after you have checked in with the receptionist.

We look forward to providing you the best possible medical care and thank you for choosing us for your cardiology needs. If you have any questions, please do not hesitate to contact us.

Board Certified in Cardiovascular Disease
Practice Limited to the Diagnosing and Treatment of Cardiovascular Diseases
201 Health Park Blvd., Suite 105 St. Augustine, FL 32086
904-824-1776 Fax 904-825-1270

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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.

Office Hours

Monday – Thursday 8:00 a.m. – 4:30 p.m. Friday 8- 12:30 pm afternoon hours vary
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. As a courtesy, we call to remind patients of their appointments 48 hours in advance, in order to provide time to fill the vacant appointments. There are circumstances that require us to adjust appointment times. **PLEASE** listen to confirmation messages as your appointment time may have been adjusted. 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 4 PM. Calls are answered according to urgency. When leaving messages, please get the name of the staff you were speaking with. If your call is not answered within 24 hrs, please notify the office manager. If you are having medical issues that need attention, please call as early as possible, so we have time to address issues. Or use your patient portal to send messages to our staff.

Prescriptions & Renewals

All prescriptions and authorizations for renewals should be **requested through your pharmacy**. Please follow your doctor's 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. We only fill prescriptions written by our physicians, and legally we can only refill medications if you have been seen within the past year.

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.

Revised 10/2022

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ **Primary Care Physician:** _____

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)

- | | |
|---|--|
| <input type="checkbox"/> Chest discomfort / pain | <input type="checkbox"/> Irregular / Rapid / Forceful heartbeats |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting episodes or "Blacking out" |
| <input type="checkbox"/> Swelling in your legs | |
| <input type="checkbox"/> Dizziness or lightheadedness | |
| <input type="checkbox"/> Other: _____ | |

PAST MEDICAL HISTORY

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

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

HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR PROCEDURES?

	When	Where
<input type="checkbox"/> EKG (electrocardiogram)	_____	_____
<input type="checkbox"/> Stress Test (Treadmill or Chemical)	_____	_____
<input type="checkbox"/> Heart Catheterization/Angiogram	_____	_____
<input type="checkbox"/> Carotid Ultrasound/ Surgery	_____	_____
<input type="checkbox"/> Abdominal Aorta Ultrasound	_____	_____
<input type="checkbox"/> Other Angiogram	_____	_____
<input type="checkbox"/> Angioplasty and/or Stent	_____	_____
<input type="checkbox"/> Coronary Bypass Surgery (CABG)	_____	_____
<input type="checkbox"/> Other bypass surgery	_____	_____
<input type="checkbox"/> Echocardiogram (Cardiac Ultrasound)	_____	_____
<input type="checkbox"/> Cardiac valve surgery	_____	_____
<input type="checkbox"/> Pacemaker or defibrillator implantation	_____	_____
<input type="checkbox"/> CT of the Chest (within the last 3 years)	_____	_____

OVER

NAME: _____

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? _____ COVID Vaccine? **Date:** _____
_____ Have you ever received a blood transfusion?
_____ Have you travelled outside of the United States in the past 12 months? If yes. Where? _____
_____ Do you have an advance directive and/or a living will? Please provide a copy
Are there any other medical issues that were not covered on this form? If so please list:

Thank you

Revised 2/2021

ST. AUGUSTINE CARDIOLOGY ASSOCIATES, PA

Ferris E. George, MD Robert N. Signor, MD
Billie J. Russell, PhD., APRN-BC Madelyn R. Pellicer, APRN, FNP-C

To All Patients of St Augustine Cardiology Associates

In order to assist our physicians in treating and prioritizing medical issues in our practice, we have employed Billie Russell, PhD., APRN-BC and Madelyn Pellicer, APRN, FNP-C. Please be aware that very frequently patients in our practice will be seeing our APRN's. 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. It is sometimes necessary to adjust patient appointment times, so it is important to listen to the courtesy reminder call of your appointment.

We appreciate your understanding in this matter. If you have any special requests involving the above issues please bring it to the attention of the receptionist prior to your visit so that we may best try to accommodate you.

Thank you
St. Augustine Cardiology Associates

Signature: _____ Date: _____

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We are required by law to maintain the privacy of, and provide individuals where to obtain a 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 HIPAA Compliance Officer in person or by phone at 904-824-1776.

Your signature below is only acknowledgment that you have received the instruction on where to find the "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. **PLEASE REVIEW AND UPDATE AS NECESSARY**

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

"NOTICE OF PRIVACY POLICIES" can be found on our website at www.staugustinecardiology.com , under the "Services" tab (new patient packet) or on the bulletin board in our office waiting room. If you would like a paper copy, we will be happy to provide you with one

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PRE-APPOINTMENT MEDICAL RECORD RELEASE

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 Statute 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: _____