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

_____.

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.

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

Please be aware very frequently patients in our practice will be seeing our APRN's, any acute medical issues are brought to the attention of our physician's immediately.

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

www.staugustinecardiology.com

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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

St. Augustine Cardiology Assoc., P.A.
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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)

___ Chest discomfort / pain
___ Shortness of breath
___ Swelling in your legs
___ Dizziness or lightheadedness
___ Other:_____
___ 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	_____	_____
___ CT of the Chest (within the last 3 years)	_____	_____

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:

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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St. Augustine Cardiology Associates, PA
201 Health Park Blvd., Suite 105
St Augustine, Florida 32086
T: (904) 824-1776 F: (904) 825-1270

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,EKG ect)**
- **( ) OTHER: _____**

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

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

PLEASE MAIL IF RECORDS ARE MORE THAN 10 PAGES- THANK YOU

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**: _____

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