Cardiovascular Medicine
Equbal Kalani, MD, FACC
1501 South Pinellas Avenue, Suite S, Tarpon Springs, FL 34689
Phone: (727)-943-2880 Fax: (727)-943-2878

INTERNATIONAL BOARD OF HEART RHYTHM EXAMINERS
CERTIFIED CARDIAC DEVICE SPECIALIST
PHYSICIAN

Name: _____ Date: _____
First Middle Last

Birthdate: _____ Age: _____ SSN: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: ( ) _____ Mobile: ( ) _____

PLEASE COMPLETE THE FOLLOWING ONLY IF YOU ARE NOT A FULL-TIME FLORIDA RESIDENT

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____

EMPLOYMENT INFORMATION, IF APPLICABLE:

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work phone: ( ) _____

Name of Spouse: _____ Phone: ( ) _____

In case of emergency, contact: _____ Relationship: _____

Home Telephone: ( ) _____ Work phone: ( ) _____

Insurance Information

Patient's Name: _____ Date: _____
First Middle Last

[Primary Insurance]
Name of Insurance Company:
_____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____

Group Number: _____ Policy ID Number: _____

[Secondary Insurance]
Name of Insurance Company:
_____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____

Group Number: _____ Policy ID Number: _____

In this a work related injury or illness? ☐ Yes ☐ No

*PLEASE BE AWARE OUR OFFICE IS NOT A PARTICIPATING PROVIDER IN WORKERS COMPENSATION

Our office will file insurance for all reimbursable services,to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pays, and non-covered service amounts.

I authorize the release of all medical information deemed necessary to process my insurance claims.

Signed: _____

Patient or responsible party

Date: _____

I authorize payment and assignment of medical and surgical benefits to Equbal Kalani, MD

Signed: _____

Patient or responsible party

Date: _____

Complete this section only if someone other than the patient is financially responsible for your medical bills.

Responsible party: _____ Relationship to patient:_____

Home Address:_____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Birthdate: _____ Age: _____

COPAYS ARE DUE AT TIME OF SERVICE-WE ACCEPT CREDIT CARD AND DEBIT CARDS AS WELL AS CASH AND PERSONAL CHECKS!

PLEASE NOTE,PAYMENT IS DUE WHEN SERVICES ARE RENDERED!

MEDICATIONS MUST BE BROUGHT TO <u>EVERY VISIT</u> IN THE ORIGINAL BOTTLES!

It is our office policy to take photos of our patients. This photo is used for the purpose of easy identification by the physician and staff only. Your photo will be not released to anyone in any form,including printed or transmitted via fax or internet.

☐ I do consent to the aquisition of my photo for the above purpose only.

☐ I do (not) consent to the acquisition of my photo for the above purpose only.

_____ _____
PATIENT SIGNATURE DATE

I have received a copy of Dr.Kalani's HIPAA/confidentiality statement. I am also aware that a copy is posted in clear sight in the office of Dr. Kalani.

_____ _____
PATIENT SIGNATURE DATE

How did you learn about our practice? _____

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

Please Fill out this Form for Compliance with the Patient Self Determination Act passed by the State of Florida

You cannot remove all uncertainty about your future healthcare needs but by having an advance directive you can have the peace of mind that comes from making your wishes known in advance!

Declaration To Decline Life Prolonging Procedure (Living Will)

- ☐ I have made a Living Will
- ☐ I do NOT have a Living Will

Health are Surrogate

- ☐ I have designated a Health are Surrogate
- ☐ I have NOT designated a Health are Surrogate

Durable Power of Attorney

- ☐ I have appointed a Durable Power of Attorney for Health Care decisions.
- ☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions.

_____
(Print Name)

_____
Signature of Patient or Representative

_____
Date

If you have any further questions, you can contact your family attorney, local hospital, local medical association, or our office for additional information.

Omnibus Budget Reconciliation Act of 1990 (Patient Self-Determination Act)
Chapter 765, Florida Statutes

Medical History Information Form-Page 1

Name: _____
First Middle Last

HISTORY

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS:

Location: _____
Where is the problem?

Duration _____
EXAMPLE:Color of sputtum

Severity: _____
How severe is the problem?

Content _____
How long have you had this problem?

Timing: _____
Other associated problems?

Factors: _____
What makes this problem worse?
Any previous episodes

Patient medica history:

Diabetes	☐ No	☐ Yes
Hypertension	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Heart Trouble	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes
Gout	☐ No	☐ Yes
Convulsions	☐ No	☐ Yes
Bleeding Tendency	☐ No	☐ Yes
Acute Infections	☐ No	☐ Yes
Venereal Disease	☐ No	☐ Yes
Hereditary Diseases	☐ No	☐ Yes

Previous Hospitalizations/Surgeries/Serious Injuries

_____
_____
_____
_____

Medications

_____
_____

PATIENT SOCIAL HISTORY:

Marital status:	☐ Single	☐ Married	☐ Separated	☐ Widowed
Alcohol use:	☐ Never	☐ Rarely	☐ Moderate	☐ Daily
Tobacco use:	☐ Never	Previously, quit in _____	Current packs/day _____	
Drug use:	☐ No	Previously, but quit in _____	Type/frequency _____	

FAMILY MEDICAL HISTORY:

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
Father			
Mother			
Siblings			
Spouse			
Children			

Medical History Information Form-Page 2

CONSTITUTIONAL SYMPTOMS

Good general health lately	☐ No	☐ Yes
recent weight change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headache	☐ No	☐ Yes

EYE

Eye disease or injury	☐ No	☐ Yes
Wear glasses/contact lenses	☐ No	☐ Yes
Blurred or double vision	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes

EARS/NOSE/MOUTH/THROUGHT

Hearing loss or ringing	☐ No	☐ Yes
Earaches or drainage	☐ No	☐ Yes
Chronic sinus problems/rhinitis	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Mouth sores	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Bad breath or bad taste	☐ No	☐ Yes
Sore throat or voice change	☐ No	☐ Yes
Swollen glands in neck	☐ No	☐ Yes

CARDIOVASCULAR

Heart trouble	☐ No	☐ Yes
Chest pain/angina	☐ No	☐ Yes
palpitations	☐ No	☐ Yes
Shortness or breath/walking or lying flat	☐ No	☐ Yes
Swelling of feet, ankles,hands	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent cough	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes

GASTROINTESTINAL

Loss of appetite	☐ No	☐ Yes
Change in bowel movements	☐ No	☐ Yes
Nausea or vomiting	☐ No	☐ Yes
Frequent diarrhea	☐ No	☐ Yes
Painful bowel movements or constipation	☐ No	☐ Yes
Rectal bleeding or blood in stool	☐ No	☐ Yes
Abdominal pain or heartburn	☐ No	☐ Yes
Peptic ulcer (stomach or duodenal)	☐ No	☐ Yes

GENITOURINARY

Frequent urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Change in force of strain when urinating	☐ No	☐ Yes
Incontinence or dribbling	☐ No	☐ Yes
Kidney stones	☐ No	☐ Yes
Sexual difficulty	☐ No	☐ Yes
Male-testicle pain	☐ No	☐ Yes
Female-pain with periods	☐ No	☐ Yes
Female-irregular periods	☐ No	☐ Yes
Female-vaginal discharge	☐ No	☐ Yes

Female- _____ pregnancies miscarriages- _____ none

Female_date of last pap smear _____

MUSCULOSKELTAL

Joint pain	☐ No	☐ Yes
Joint stiffness or swelling	☐ No	☐ Yes
Weakness of muscles or joints	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Cold extremities	☐ No	☐ Yes
Difficulty walking	☐ No	☐ Yes

SKIN, BREAST

Rash or itching	☐ No	☐ Yes
Change in skin color	☐ No	☐ Yes
Change in hair or nails	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Breast lump	☐ No	☐ Yes
Breast dicharge	☐ No	☐ Yes

NEUROLOGICAL

Frequent or recurring headaches	☐ No	☐ Yes
Light headed or dizzy	☐ No	☐ Yes
Convulsions or seizures	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Head Injury	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion	☐ No	☐ Yes
Nervousness	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent cough	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes

ENDOCRINE

Glandular or hormone problems	☐ No	☐ Yes
Thyroid disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Excessive thirst or urination	☐ No	☐ Yes
Heat or cold intolerance	☐ No	☐ Yes
Skin becoming dryer	☐ No	☐ Yes
Change in hat. or glove size	☐ No	☐ Yes

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	☐ No	☐ Yes
Bleeding or bruising tendency	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes
Past transfusion	☐ No	☐ Yes
Enlarge glands	☐ No	☐ Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillion or other antibiotics	☐ No	☐ Yes
Morphine, Demerol, narcotic	☐ No	☐ Yes
Novacine, other anesthetics	☐ No	☐ Yes
Aspirin or other pain remedies	☐ No	☐ Yes
Tetanus antitoxin/other serums	☐ No	☐ Yes
Iodine,metholate, antiseptics	☐ No	☐ Yes

Other drugs/medications

Known food allergies _____

_____

RELEASE OF MEDICAL INFORMATION
TO DR'S, FAMILY & FRIENDS

Name: _____
First *Middle* *Last*

Date of Birth: _____ SSN: _____

I hereby give authorization for release of medical information to be released to the following:

_____ _____
NAME *RELATIONSHIP*

_____ _____
NAME *RELATIONSHIP*

_____ _____
NAME *RELATIONSHIP*

The information to be release will be limited to the following:

- ☐ Diagnosis
- ☐ Medication
- ☐ Test results
- ☐ Insurance Information
- ☐ Appointments
- ☐ Psychiatric Notes
- ☐ HIV Test results/STD
- ☐ Alcohol Use
- ☐ Other: _____ *Please specify*

☐ Release all medical information

Upon release of this information to the above named our office will make every attempt to verify/authenticate the person receiving this information is the person the patient has designed. Due to HIPAA regulations a specific consent must be signed to release information to anyone other than a patient: including doctors, children,spouse, and friends.

My consent to release this information to the above named is effective until retracted in writing by me or one year from the date it was issued.

This release is effective from _____ and expires on _____ .
Today's Date *1 Year*

This release may be revoked at any time with the patients' written request.

_____ _____
Patient Signature *Date*

_____ _____
Witness Signature *Date*

Name: _____ **D.O.B.** _____

Date. _____

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐ Y	☐ N	Leg:	☐ R	☐ L
Phlebitis (vein redness/tenderness)	☐ Y	☐ N	Leg:	☐ R	☐ L
Blood clots	☐ Y	☐ N	Leg:	☐ R	☐ L
Deep vein thrombosis (DVT)	☐ Y	☐ N	Leg:	☐ R	☐ L
Saphenous vein reflux	☐ Y	☐ N	Leg:	☐ R	☐ L

Do you experience any of the following in your leg(s):

Aching/pain	☐ Y	☐ N	Leg:	☐ R	☐ L
Heaviness	☐ Y	☐ N	Leg:	☐ R	☐ L
Tiredness/fatigue	☐ Y	☐ N	Leg:	☐ R	☐ L
Itching/burning	☐ Y	☐ N	Leg:	☐ R	☐ L
Swelling	☐ Y	☐ N	Leg:	☐ R	☐ L
Cramps	☐ Y	☐ N	Leg:	☐ R	☐ L
Throbbing	☐ Y	☐ N	Leg:	☐ R	☐ L
Skin or ulcer problems	☐ Y	☐ N	Leg:	☐ R	☐ L
Other	☐ Y	☐ N	Leg:	☐ R	☐ L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐ Y	☐ N	What? _____
Elevation of legs	☐ Y	☐ N	What? _____
Wear support hose	☐ Y	☐ N	What? _____

II. Family History

Have any of your family members had:

Varicose veins	☐ Y	☐ N	Who? _____
Vein stripping	☐ Y	☐ N	Who? _____
Blood coagulation disorder	☐ Y	☐ N	Who? _____
Blood clots	☐ Y	☐ N	Who? _____
Stroke,heart attack or pulmonary emboli	☐ Y	☐ N	Who? _____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

Sclerotherapy	☐ Y	☐ N	Leg:	☐ R	☐ L
Laser therapy (spider veins)	☐ Y	☐ N	Leg:	☐ R	☐ L
Phlebectomy	☐ Y	☐ N	Leg:	☐ R	☐ L
Vein stripping surgery	☐ Y	☐ N	Leg:	☐ R	☐ L
R F ablation (VNUS Closure®)	☐ Y	☐ N	Leg:	☐ R	☐ L

IV. Activities List

Does your work require:

Prolonged standing periods	☐ Y	☐ N	
Prolonged sitting periods	☐ Y	☐ N	
Do you exercise regularly?	☐ Y	☐ N	
Do you smoke?	☐ Y	☐ N	
Pregnancies	☐ Y	☐ N	How many? _____

OFFICE POLICIES
EFFECTIVE JANUARY 1st ,2011

Attention all patients:

Please see below a copy of our office policies. If you have any questions please feel free to ask any of our staff.

INFORMATION CHANGES:
We ask all patients to verify your information, and notify staff of any changes as soon as possible. This includes address, phone number, pharmacy and INSURANCE information etc.

CO PAYMENT,CO-INSURANCES & DEDUCTIBLES:
If you insurance requires a co-payment, co-insurance or your deductible is not met at the time of service, in accordance to your plan, you are responsible to pay the amount due prior to being seen by the doctor.(Straight Medicare Excluded).

RETURNED CHECKS:
It is our policy to charge $25.00 for all returned checks made out to our office. Payment including returned check fee must be "PAID IN FULL" prior to next appointment unless other arrangement are made.

MISSED/NO SHOW APPOINTMENTS:
It is policy to charge $25.00 for all missed appointment where the patient does not show up for their scheduled appointment after it has been confirmed with the patient. This fee must be "PAID IN FULL" prior to next appointment. We ask for 24 hour notice if you need to change your appointment. We reserve the right to cancel an appointment if it is not confirmed.

PRESCRIPTION REFILLS:
Please ask for your refills at time of visit. If you need a refill in between visits,please give us 3 days notice. While we try to get all refills out the same day we cannot predict if the doctor is needed in an *emergency* situation and has to leave the office abruptly. We ask you not wait until the day you run out as this may not allow enough time if you may need authorizations for certain medications.

By signing below I am acknowledging the fact I have been informed of the above policies.

_____ _____

Patient Signature Date

MEDICAL RECORDS RELEASE FOR CONTINUING CARE

Patient Name: _____	SS#: _____ DOB: _____
Information Requested From: Name: _____ Address: _____ Phone: _____ Fax: _____	**Recipient of Records:** Cardiovascular Medicine Equbal Kalani,MD,FACC 1501 South Pinellas Avenue, Suite S, Tarpon Springs, FL 34689 Phone: (727)-943-2880 Fax: (727)-943-2878 International Board of Heart Rhythm Examiners Certified Cardiac Device Specialist Physician

INFORMATION TO BE DISCLOSED:

Description	Description	Super Confidential Records
☐ Medical records for continuity of Care	☐ Most recent one year hostory	☐ Alcohol and drug therapy notes
☐ Physician Dictated Notes	☐ Entire Medical Records (all info)	☐ Communicable disease (HIV,HBV, TB)
☐ Office Notes & Reports	☐ Transcribe hospital reports	☐ Psychotherapy office notes
☐ Clinician office chart notes	☐ Diagnostic imaging/x-ray reports	☐ Other _____
☐ Billing statement	☐ Laboratory reports	☐ Other _____

PLEASE SEND THE FOLLOWING: ☐ Last 3 Progress Notes, Recent Labs, X-Rays, Testing, Consultations, Medication Sheets and Summary of Care

Purpose of Disclosure:

☐ Ongoing Continued Medical Care	☐ Insurance	☐ Disability
☐ Patient's Request	☐ Legal follow-up	☐ Personal Information

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoke at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

_____ _____
Print Patient's Name Date

_____ _____
SIGNATURE OF PATIENT or Patient's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

Notice of Privacy Practices for Protected Health Information (HIPAA)

"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information".Please Review It Carefully!

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only designated staff and only for designated reasons. Housekeeping, maintainance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies,hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as :

- When required by law
- Public health activities (deaths,child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/ prevention)
- Health oversight activities (audits,investigations)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners,medical examiners, funeral directors.
- Organ and tissue donation
- Research,provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster Relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights:

You Have The Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available. You may also get an electronic copy if we have one available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years,starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supercede the typical disclosures noted above. You may revoke or restrict the consent. We cannot disclose self-pay services if you object.
- Request confidential communications. All communications in our office are confidential. You may specifically-request that all communications be confidential with a written request directed to our office.
- Not have your protected health information sold for marketing purposes.
- Opt out of receiving fund-raising communications.
- Receive a copy of this notice by printing it or with a written request directed to the office, and a copy of this notice will be given with all new patient packets.

We May Contact You For Appointment Reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our <u>PRIVACY OFFICER</u> at our office.

If you get no resolution to your complaint, you can send a written statement to to this office or the Secretary of Health and Human Services.

Effective Date of Notice:

Amended Dates: February 2011