

511 Medical Plaza Drive, Suite 101, Leesburg, FL 34748  
phone 352.728.6808 fax 352.728.1743  
fhvhealth.com

To our new patient,

**Welcome!** On behalf of the staff at FHV Health, we would like you to know that we are honored to have you as a new patient to our practice. We look forward to providing you with the highest quality of care from the best trained technical staff Florida has to offer. We provide a variety of treatment plans and procedures using the most sophisticated medical equipment in the area.

Enclosed you will find several forms that will need to be completed by your first appointment date. These forms will be available in the front office on the day of your appointment, but we wanted you to have the option to fill them out from the comfort of your home, if you prefer.

As a patient of FHV Health, you have round-the-clock access to a nurse or health care professional. If you are sick or need medical advice, you can always **call us first at 352-205-4439**. When you dial our 24/7 health care hotline, a trained health care professional will advise you on whether you should visit your primary care provider, our Urgent Care Center, or an emergency room.

Please remember these important things regarding your first visit to our office:

- Bring **all** your medications in a bag to **each** office visit.
- Sign the enclosed "Record Release" form for us to obtain previous records of your care.
- Keep us updated on studies or surgeries you've had since we last saw you. If you spend part of the year in another area, be sure to bring copies of any studies back with you or mail them to us.
- If you have any questions or concerns, feel free to call us during business hours at **352-728-6808** or visit **fhvhealth.com**. We promise to do everything we can to get you the information you need.

Once again, welcome to FHV Health. We look forward to your visit with us.

**Yours in Health,**

FHV Health Physicians and Staff

---

PATIENT PRINTED NAME

DATE OF BIRTH

## Medical Release Authorization

I hereby authorize and request \_\_\_\_\_ to release medical information concerning my medical care to FHV Health for the following purpose(s):

---

SPECIFIC PURPOSE FOR DISCLOSURE OF RECORD

The type and amount of information to be disclosed is as follows: *(Specify dates where appropriate)*

- |                                |  |
|--------------------------------|--|
| _____ History and physical     | _____ Stress test reports                    |
| _____ Discharge summary        | _____ Cardiac catheterization reports/images |
| _____ Lab results              | _____ Peripheral ultrasound reports          |
| _____ EKGs                     | _____ Abdominal ultrasound reports           |
| _____ Echocardiogram reports   | _____ Carotid ultrasound reports             |
| _____ Chest x-ray reports      | _____ Peripheral angiogram reports/images    |
| _____ Most recent office notes | _____ Other, please specify: _____           |

I understand that the information may include the release of information concerning HIV testing or treatments of AIDS or AIDS-related conditions, drug or alcohol abuse (or related conditions), and mental health conditions.

I understand the use or disclosure of my individual health information, as described above. I understand that this authorization will expire, without my express revocation, either one year from the date of signing or, if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that authorization for the disclosure of this health information is voluntary, and I can refuse to sign this authorization. I understand that this authorization is revocable, upon written notice to the office where the original authorization is retained.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulation, and that it may be re-disclosed by the recipient. The facility, its employees, officers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein. **Please fax records to 352.728.1743.**

---

PATIENT SIGNATURE

DATE

---

SIGNATURE OF PARENT OR LEGAL REPRESENTATIVE



## Information Regarding the Health Insurance Portability & Accountability Act

**This notice describes how medical information about you may be used and disclosed, and how you can access this information. Please read it carefully.**

The **Health Insurance Portability & Accountability Act (HIPAA)** of 1996 is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, to be kept properly confidential. This Act gives you, the patient, rights to control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are maintaining the privacy of your health information and how we may use and disclose your health information.

We at FHV Health create a medical chart with your personal medical information, along with a computerized account for payment. Treatment: We may use and disclose information about you to provide you with medical care. We may disclose information about you to other physicians or those designated on the "Authorization To Release Information." Payment: We may use medical information, along with Insurance information, and any additional information provided, in order that payment for services is received. Operations: We may use and disclose PHI from you for normal daily medical operation of our office. We may also disclose information to our Business Associates who provide contracted services for us (accounting, legal representation, claims processing, consulting, etc.). We may contact you to remind you of appointments, health related issues, or billing concerns. Every effort will be made to comply with any particular request or restriction designated in writing.

### Your Rights Regarding Medical Information About You

(1) You have the right to request restrictions on certain uses and disclosures of Protected Health Information. We are however not required to agree to a requested restriction and should we not agree may request you seek another physician. (2) The right to reasonable requests to receive confidential communication of protected health information from us. This request must be in writing. (3) The right to request an amendment. Should you feel the medical information is incorrect or incomplete, you may request an addition or amendment. Requests must be made in writing and submitted to FHV Health, with attention to your attending physician. If you desire your medical record to be changed there is a form, which will be sent to you. The physician may decline your request if it's not accurate. (4) Right to an Accounting of Disclosures. You have a right to request a list of certain types of disclosures we have made of your medical information. We are not required to account for disclosures that were authorized by you, to carry out treatment, payment and healthcare operations.

**I have read the Health Insurance Portability & Accountability Act of 1996 and understand my rights.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED FIRST NAME

\_\_\_\_\_  
PRINTED LAST NAME

If you would like a copy of this form, Please ask the front receptionist.



## HIPAA Patient Consent Form

I consent to the use or disclosure of my protected health information by FHV Health for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of FHV Health. I understand that diagnosis or treatment of me by FHV Health physicians may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. FHV Health is not required to agree to the restrictions that I may request, and may request I seek another physician. However, if FHV Health agrees to a restriction that I may request, the restriction is binding.

I have the right to revoke this consent in writing at any time, except to the extent that FHV Health has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The FHV Health Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the FHV Health. The Notice of Privacy Practices for FHV Health is also provided in the reception area. This notice of Privacy Practices also describes my rights and the FHV Health duties with respect to my protected health information.

FHV Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of private practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

---

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

---

DATE



## Authorization for Disclosure of Health Information

Many of our patients allow family members, such as their spouse, significant other, parents and/or children to call and request results of tests, procedures and financial information. Under the requirements of HIPAA, we are not permitted to give this information to anyone without the patient's written consent.

If you wish to have your medical information, diagnostic test results, and/or financial information released to any individuals or family members, you must sign and list them on this form.

The facility, its employees and physicians, are hereby released from any liability for the disclosure of information released therein. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

**I authorize FHV Health to release any or all information concerning my medical care to the following individuals:**

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

I authorize FHV Health to leave normal test results on my answering machine or voicemail.

PATIENT PRINTED NAME	DATE OF BIRTH	SSN
PATIENT SIGNATURE	DATE	
WITNESS SIGNATURE	DATE	



# THORACIC AND VASCULAR SURGERY (352) 728-6904

## HISTORY & PHYSICAL

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ BP: \_\_\_\_\_ PULSE: \_\_\_\_\_ RES: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_

### ALL DOCTORS WITH WHOM PATIENT HAS ESTABLISHED RELATIONSHIP

\_\_\_\_\_  
\_\_\_\_\_

### HISTORY OF PRESENT ILLNESS (HPI):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PAST HOSPITALIZATIONS & SURGERIES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PAST MEDICAL HISTORY [Patient please circle yes (Y) or no (N)]

CONDITION	YES	NO	COMMENTS
High Blood Pressure	Y	N	_____
Respiratory Problems	Y	N	_____
Bleeding Problems	Y	N	_____
Diabetes	Y	N	_____
Stroke	Y	N	_____
HIV/AIDS	Y	N	_____
Heart Trouble	Y	N	_____
Cancer	Y	N	_____
Liver Disease (hepatitis , cirrhosis )	Y	N	_____
Kidney Disease	Y	N	_____
MRSA Infection	Y	N	_____
Sleep Apnea	Y	N	_____
Other Problems	Y	N	_____

Do you or a family member have a history  
of: Cancer yes no      Kidney disorders: yes no

Cardiovascular disease yes no

# THORACIC AND VASCULAR SURGERY

(352) 728-6904

## HISTORY & PHYSICAL - TO BE COMPLETED BY PATIENT

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

### CURRENT MEDICATIONS:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### ALLERGIES:

\_\_\_\_\_

### REVIEW OF SYSTEMS [Patient please circle yes (Y) or no (N)]

<b>CONSTITUTIONAL</b>	YES	NO	<b>EAR/NOSE/MOUTH/THROAT</b>	YES	NO	<b>EYES</b>	YES	NO
Good General Health	Y	N	Hearing Loss or Ringing	Y	N	Wear Glasses/ Contacts	Y	N
Recent Weight Change	Y	N	Sinus Problems	Y	N	Blurred/ Double Vision	Y	N
Night Sweats, Fevers	Y	N	Nose Bleeds	Y	N	Eye Disease or Injury	Y	N
Fatigue	Y	N	Sore Throat/ Voice Change	Y	N	Glaucoma	Y	N
<b>CARDIOVASCULAR</b>	YES	NO	<b>RESPIRATORY</b>	YES	NO	<b>GASTROINTESTINAL</b>	YES	NO
Chest Pain	Y	N	Shortness of Breath	Y	N	Nausea/Vomiting	Y	N
Palpitations	Y	N	Cough	Y	N	Abdominal Pain Rectal	Y	N
Heart Trouble	Y	N	Wheezing/ Asthma	Y	N	Bleeding Bowel	Y	N
Swelling Hands/ Feet	Y	N	Coughing Up Blood	Y	N	Problems	Y	N
<b>MUSCULOSKELETAL</b>	YES	NO	<b>NEUROLOGICAL</b>	YES	NO	<b>SKIN/BREAST</b>	YES	NO
Muscle Pains/Cramps	Y	N	Frequent Headaches	Y	N	Changes in Hair or Nails	Y	N
Stiffness/Swelling Joints	Y	N	Paralysis or Tremors	Y	N	Rashes or Itching	Y	N
Joint Pain Trouble	Y	N	Convulsion/Seizures	Y	N	Breast Lump	Y	N
Walking	Y	N	Numbness/ Tingling	Y	N	Breast Pain or Discharge	Y	N
<b>ENDOCRINE</b>	YES	NO	<b>HEMATOLOGIC/LYMPHATIC</b>	YES	NO	<b>ALLERGIC/IMMUNOLOGIC</b>	YES	NO
Excessive thirst/urination	Y	N	Bruise Easily	Y	N	Food Allergies	Y	N
Thyroid Disease	Y	N	Slow to Heal	Y	N	Aspirin Allergies	Y	N
Hormone Problem	Y	N	Enlarged Glands	Y	N	Antibiotic Allergies	Y	N
<b>GENITOURINARY-MALE</b>	YES	NO	<b>GENITOURINARY-FEMALE</b>	YES	NO	<b>PSYCHIATRIC</b>	YES	NO
Blood in Urine	Y	N	Blood in Urine	Y	N	Insomnia	Y	N
Kidney Stones	Y	N	Kidney Stones	Y	N	Confusion/Memory	Y	N
Sexual Problems	Y	N	Sexual Problems	Y	N	Loss Depression	Y	N
Testicle Pain	Y	N						

### SOCIAL HISTORY (Please circle appropriate response)

**Marital Status:**      Single                      Married/Divorced                      Widowed

**Tobacco Use:**              Never                      Quit/When?                      Current Smoker                      \_\_\_\_\_ packs per

**Alcohol Use:**              Never                      \_\_\_\_\_ Rarely      Moderate                      Daily                      day How Much?

**Drug Use:**              Never                      Type & Frequency \_\_\_\_\_

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_