Baker-Gilmour Cardiovascular Institute

Web Portal Registration

Name:_______________________ Account:________________

DOB:________________________

Email Address:_______________________________________
Please Print Clearly

Security Code:_______________________________________
Last 4 digits of SSN

__________________________ ________________
Signature Date

I, hereby give permission for Baker-Gilmour Cardiovascular Institute to use my email for the purpose of the Baker-Gilmour, FollowMyHealth Portal.

You will only receive the emails that you permitted upon subscription. Your email address will never be shared with any 3rd party and you will receive only the type of content for which you signed up for.

BAKER-GILMOUR CARDIOVASCULAR INSTITUTE
HIPAA AUTHORIZATION

I ________________________________ DOB:______________ authorize
Patient's Name

Baker-Gilmour Cardiovascular Institute to disclose and allow the following people to have access to ALL of my personal and confidential medical information including by phone, to pick up records for me, and financial information.

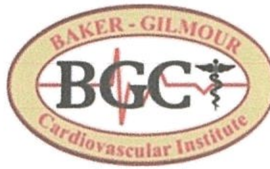
Name of Person	DOB	Phone Number
________________	__________	________________
________________	__________	________________
________________	__________	________________

I understand:

- This is a full release of all my medical information-**including mental health, drug, alcohol, HIV/AIDS and other sexually transmitted disease information**
- **I do not have to sign this form.** My refusal will not change my ability to get treatment, payment for treatment or benefits.
- Once information is shared as allowed by this Authorization, it may not be protected by law. Someone may be able to share my information with others without my permission.
- This Authorization is effective until (1 year from today):__________________________
- I can cancel this Authorization at any time. If I want to cancel it, I will send written notice to my doctor's office. I cannot cancel this Authorization as to information that has already been shared.
- Baker-Gilmour cannot use my medical information without my permission, except in the ways described in Baker-Gilmour's Notice of Privacy Practices.
- Upon my request, I have been given a copy of this form.

I have read this form or had it read to me. I understand it. I have had a chance to ask questions, and my questions were answered to my satisfaction. I sign this form voluntarily.

______________________________ ______________________________
Patient's Signature Date Witness Signature Date



Baker-Gilmour Cardiovascular Institute

3550 University Blvd South, Suite 302
Jacksonville, FL 32216
P. 904.733.4444 F. 904.733.5377

300 Health Park Blvd, Suite 1006
St. Augustine, FL 32086
P. 904.794.7050 F. 904.794.7135

Release of Medical Information Request Form

Information Being Released to:	Information Being Released from:
Baker-Gilmour Cardiovascular Institute **(circle location)**	______________________________ ______________________________

Information Requested | Information Disclosed:

Name of Patient:______________________________

DOB: ______________ SSN:______________________

Expiration Date of Authorization
This authorization is effective through____/_____/_____ unless revoked or terminated by the patient or the patient's person representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Baker-Gilmour Cardiovascular Institute to the attention of Medical Records

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it has been sent. The privacy of this information may not be protected under the federal privacy regulations.

The release of any information considered super-confidential under Florida Law, such as that regarding psychiatric, drug, or alcohol abuse, HIV/AIDS testing, counseling, or treatment or sensitive materials which may or may not be in my medical records is hereby
______Authorized or ______Not Authorized

I further understand that Florida Statues (Rule 38F-7.601. Florida Administrative Code) allow health care providers to charge no more than $1.00 per page for the first 25 pages of written materials, 25 cents for each additional page and the actual cost of reproducing non-written reports such as x-rays, except in the case of Workers Compensation (where the charge is only 50 cents per page)

Printed Patient Name:______________________________

Signature of Patient:______________________ Date:______________

Patient Representative Name (if patient is unable to sign)______________________

Signature of Representative:______________________ Relationship:______________

Baker-Gilmour Cardiovascular Institute

Adult Cardiology

Patient Information **(All Information is Confidential)**

GENERAL PATIENT INFORMATION		
1. Last Name:	First:	Middle:
2. Sex: (check one) ☐ Male ☐ Female	3. Date of Birth: (month/day/year) / /	
4. Personal Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Ethnicity ______ Language ______ Race ______		
5. Social Security Number:		6. Age:
7. Local Address:		
8. Phone Numbers: Home ( ) Work ( ) Cell Email		
9. Permanent Address:		
10. City:	11. State:	12. Zip Code:
INSURANCE INFORMATION		
13. **Primary Plan** Effective Date: / / ☐ HMO ☐ Medicare ☐ Medicaid ☐ PPO ☐ Traditional ☐ WC (see below) ☐ Other		
14. Insurance Company Name:		
15. Insured's Name (other than patient):		
16. Insured's SSN (other than patient):		17. Date of Birth: / /
18. Insured's Relationship to Patient (check one): ☐ Self ☐ Spouse ☐ Parent ☐ Other		
19. Policy or Contract Number:	20. Group Number:	
21. **Secondary Plan** Effective Date: / / ☐ HMO ☐ Medicare ☐ Medicaid ☐ PPO ☐ Traditional ☐ WC (see below) ☐ Other		
22. Insurance Company Name:		
23. Insured's Name (other than patient):		
24. Insured's SSN (other than patient):		25. Date of Birth: / /
26. Insured's Relationship to Patient (check one): ☐ Self ☐ Spouse ☐ Parent ☐ Other		
27. Policy or Contract Number:	28. Group Number:	
REFERRING PHYSICIAN INFORMATION		
29. Physician Name:		Phone Number: ( )
WORKERS' COMP		
30. Date of Injury: / /	Insurance Company:	
31. Case #:	Case Mgr:	Phone:
EMERGENCY CONTACT INFORMATION		
32. Whom should we call in case of an emergency? (Name)		Phone Number: ( )
33. What is contact's relationship to patient? ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Friend ☐ Other		
34. Authorization to discuss medical information: ☐ Yes ☐ No		
Patient Signature:		Date of Signature: / /

PATIENT HISTORY

HEALTH HABITS

SPECIAL DIET? _____ None _____ Low Cholesterol _____ Diabetic _____ Low Salt

TOBACCO _____ Never _____ Cigarettes (# per day) _____ Quit

ALCOHOL _____ None _____ Rarely _____ One or more drinks per day

FLU SHOT _____ Never _____ Yearly

PNEUMONIA VACCINE? _____ Never _____ In past 7 years

Are you currently taking any narcotic substance, other than those prescribed by a licensed physician?

____

Do you have a past history of substance abuse?

____

FAMILY HISTORY

Is there a family history of: Please (✓)

	Mother	Father	Brother	Sister
High Blood Pressure	____	____	____	____
Sugar Diabetes	____	____	____	____
Heart Attack or Stroke before age 50	____	____	____	____

	Mother	Father	Brother	Sister
Cholesterol Problems	____	____	____	____
Kidney Disease	____	____	____	____
Breast Cancer	____	____	____	____
Other Cancer	____	____	____	____

ILLNESSES

Has a Doctor ever told you that you had any of the following? CIRCLE the number if the answer is YES.

1. Heart Attack
2. Stoke
3. Angina (Heart Pain)
4. High Blood Pressure
5. High Cholesterol
6. Sugar Diabetes
7. Cancer of any kind
8. Diverticulosis
9. Gout
10. Kidney Disease
11. Peptic Ulcer
12. Arthritis
13. Glaucoma
14. Asthma
15. Chronic Bronchitis
16. Hiatus Hernia
17. Enlarged Prostate
18. Gallbladder Stones
19. Thyroid Disease (High or Low)

OPERATIONS

Circle the number of any operation(s) you have had and put the date after the name of the operation.

1. Coronary Artery Bypass Surgery _________
2. Pacemaker _________
3. Balloon Angioplasty _________
4. Gallbladder removed _________
5. Carotid Artery Surgery (Neck) _________
6. Femoral Artery Surgery (Legs) _________
7. Other _________

What medications do you presently take? (Include eye drops)

____

____

____

PLEASE COMPLETE INFORMATION ON BACK OF FORM

REVIEW OF SYSTEMS

Put a check in either the YES or NO column.

During the PAST YEAR have you suffered any of the following problems?

Please CIRCLE the complaint that prompted you to make this appointment.

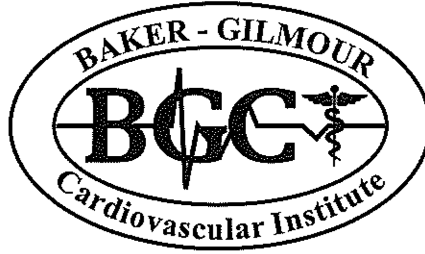
		YES	NO
1.	Racing or skipping heart	_____	_____
2.	Pains or tightness in the chest, arms or jaw with exercise	_____	_____
3.	Pain or tightness in the chest, arms or jaw with emotional upset	_____	_____
4.	Difficulty breathing with exercise	_____	_____
5.	Difficulty with breathing lying down	_____	_____
6.	Swelling of feet or ankles that is not gone after the night's sleep	_____	_____
7.	Persistent cough or hoarseness	_____	_____
8.	Significant weight loss or gain	_____	_____
9.	Skin lesion that won't heal	_____	_____
10.	Pain in the legs with walking	_____	_____
11.	Burning stomach pains on an empty stomach	_____	_____
12.	Pain or difficulty swallowing	_____	_____
13.	Faint feeling or passing out	_____	_____
14.	Significant change in bowel habits	_____	_____
15.	Recurrent weakness of an arm or leg	_____	_____

ALLERGIES

Do you have any allergies to any medications? YES _____ NO _____
If YES, list:

____

____



ASSIGNMENT OF BENEFITS

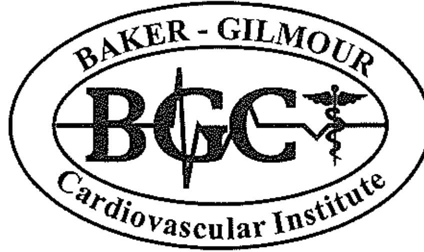
I authorize my insurance carrier to release information regarding my coverage to **Baker and Gilmour, M.D. P.A.** I also authorize agents of any hospital, treatment center or previous physicians to furnish copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Baker and Gilmour, M.D. P.A.

I authorize all payment to **Baker and Gilmour M.D. P.A.** for physical services, tests, and procedures. This assignment covers any and all benefits under Medicare; other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept the Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to **Baker and Gilmour, M.D. P.A.**

I have read and received a copy of the above statement and accept the terms. A duplicate of the statement is considered the same as original.

____ ____________________
Patient Signature Date

____ ____________________
Responsible Party Signature Relationship Date



FINANCIAL POLICY

IF YOU HAVE A REFERRAL BASED HMO/POS, IT IS YOUR RESPONSIBILITY TO MAKE SURE YOU HAVE A VALID REFERRAL UPON EACH VISIT, AND THAT YOU PAY YOUR CO-PAY AMOUNT AT CHECK-IN.

SELF PAY PATIENTS, PLEASE BE PREPARED TO PAY IN FULL AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE BILLING DEPARTMENT.

I AUTHORIZE THE RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS TO DRS. BAKER & GILMOUR.

SIGNATURE: ____

DATE: ____

Baker-Gilmour Cardiovascular Institute

3350 University Blvd. S., # 302
Jacksonville, FL 32216
904-733-4444
Fax 904-733-5377

300 Health Park Blvd., Suite 1006
St. Augustine, FL 32086
904-794-7050
Fax 904-794-7135

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

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 objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ______________________ Signature ______________________ Date ____________