



Florida Heart & Vascular

Multi-Specialty Group

Experience Our Integrity and Compassionate Care

Primary Care

Cardiology

David C. Lew, MD, FACC, FSCAI
Chairman
Jose R. Rosado, MD, FACC
Vice Chairman
John R. Hurt, MD, FACC
Patrick K. Williams, MD, FACC
Marwan Mihyu, MD, FACC
Joseph G. Sahab, MD, FACC
Michael Ruisi, MD

Vascular Surgery

David Sustarsic, MD, FACS
Jonathan A. Higgins, MD, RPVI

Family Practice

Jeffrey Robinson, MD, FAAFP, CAQG
Larry D. Foster, MD, FAAFP, CAQG
Kenneth Obiaja, MD, MPH, FAAFP
Maria Bello, MD, MPH
Tanya Diaz, MD, FAAFP
Justin P Morgan, DO
Robert A. Aisenstat, MD
Michael McGinnity, PA
Debbie Pate, ARNP, ANP-C
Tara Brannen, ARNP
Kari Baron, FNP

Internal Medicine

Fredric Davis, DO
Robert Swietarski, MD, FACP
Florian Gegaj, MD
Michael Glick, MD

Dermatology

Michael Frasure, MSN, ARNP-BC

Nephrology

Romita Mukerjee, MD, MHS
John Hayes, MD

Dear Patient,

Our goal is to provide you with the most comprehensive health care possible. Please read the information below and let us know if you have any questions. We would like to make your appointment a productive time.

Prescriptions:

We will give you all of your prescriptions at the time of your appointment. Please be prepared with all your needs when you are in the office. Telephone calls are **not** the most effective way to prescribe medication. You will get enough refills to last until your next appointment and one month extra in case you need to reschedule your appointment.

Results:

Laboratory results and diagnostic testing are important methods of evaluation in today's medicine; we will discuss the results at a follow up appointment. This will give you an opportunity to ask questions, become familiar with the meaning of the testing, discuss therapies, and plan the next step. Please make sure you schedule a follow up appointment. If your results are abnormal we will call you as soon as we get the report, **ONLY IF IT IS ABNORMAL**. Otherwise, take the opportunity to discuss all testing at your follow up appointments. You can also check your results using our patient portal. Be please sure to create your account at portal.flheartcenter.com.

After hour calls:

If you have a life threatening complaint, such as chest pain, shortness of breath, or signs of a stroke, please do not waste precious time calling, go to the ER. We cannot diagnose or prescribe medications after hours. We can only advise you if you can wait until the next business day; if you cannot, you need to go to the ER.

We do have a "Walk-In" clinic available on Saturdays from 8-2 at our Leesburg Family Medicine location (802 E. Dixie Ave, Leesburg, FL 34748)

Health Cards:

Upon checking into Florida Heart and Vascular Multi-Specialty Group as a new patient you will be provided with a Health Card. Your Health Card will include physician information, allergies, and contact information regarding Florida Heart and Vascular Multi-Specialty Group. Please keep the Health Card with your insurance cards in your wallet. When checking out you will also receive a card that includes all medications that will be updated as necessary. If at any time you require a hospital admission, please present these cards to them, so they can contact us for a consultation. You should call the number on the card if you need assistance with appointments or transfers between facilities once discharged.

Thank You for choosing Florida Heart & Vascular Multi-Specialty Group as your healthcare provider!



511 Medical Plaza Drive, Suite 101, Leesburg, FL 34748
(352) 728-6808 • Fax: (352) 728-1743

www.flheartcenter.com

Below you can review the different types of visits we offer.

It is very important you come prepared for your type of visit. If you have other needs, let the medical assistant know so we can prioritize and plan your care accordingly.

Acute care visit: this is a sick visit. A short period of time is scheduled for your urgent need. If you have other needs, you may be asked to schedule a different appointment to address this non urgent need. Always let the medical assistant know all your needs.

Physicals or Health maintenance examination: this is a routine exam that varies according to age and gender. These usually include a vaccination update, screening tests for some types of cancer and cholesterol, or other blood testing if indicated. Medicare covers one wellness visit once a year. Some commercial insurances provide a “physical” as part of their benefits. If you need your visit to be billed as a physical, please let us know. If you have other needs beside a “physical”, you may be asked to schedule a different appointment.

Chronic Disease management: If you suffer from Hypertension (high blood pressure), Diabetes (high blood sugar), Hyperlipidemia (High Cholesterol), Osteoarthritis, or any other condition that requires prescription medication, you will need an appointment at least every 6 months. At this time the chronic condition will be evaluated for appropriate control and or progression as well as side effects of the medications you take. If your chronic condition is NOT controlled, the frequency of your appointment will go to 6 weeks or 3 months until controlled. If you have an appointment for chronic disease management but have another concern or need, you may be asked to schedule a different appointment.



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Medical Release Authorization

Patient Name: _____

DOB: ____/____/____

I hereby authorize and request _____ to release medical information concerning my medical care to Florida Heart and Vascular Multi-Specialty Group, for the purpose of

(Specific purpose of disclosure of record)

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

_____ Last 3 Progress Notes	_____ Recent Colonoscopy
_____ Most Recent Laboratory Tests	_____ Eye Exam
_____ Bone Density	_____ Mammogram
_____ Most Recent Radio-Diagnostics Test	
_____ Problem List / Medication List	
_____ Other	

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 (1) year from the date of signing, or if I am a minor, on the date I become an adult according to state law, which ever 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.

Patient Signature

____/____/____
Date

Signature of Parent or Legal Representative



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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request results of tests, procedures, financial information. Under the requirements of H.I.P.A.A. we are not allowed to give any of this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any individuals/family members you must sign this form.

The facility, its employees and physicians are hereby released from any liability for the disclosure of the 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 Florida Heart & Vascular Multi-Specialty Group to release any or all information concerning my medical care to the following individuals.

_____	_____	_____
Name	Relationship to Patient	Phone

_____	_____	_____
Name	Relationship to Patient	Phone

_____	_____	_____
Name	Relationship to Patient	Phone

_____	_____	_____
Name	Relationship to Patient	Phone

_____	_____	_____
Name	Relationship to Patient	Phone

_____	_____	_____
Patient Name (Print)	Date of Birth	Social Security #

_____	_____
Patient Signature	Date

_____	_____
Witness Signature	Date



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PLEASE PRINT- USE BLACK OR BLUE INK ONLY

TODAY'S DATE _____

PATIENT INFORMATION	LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH	
	HOME STREET ADDRESS				CITY	STATE	ZIP
	HOME PHONE ()		CELL PHONE ()		WORK PHONE ()		
	SECONDARY HOME STREET ADDRESS				CITY	STATE	ZIP
	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.		MARITAL STATUS			
	EMAIL ADDRESS				DO YOU HAVE A LIVING WILL? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE PROVIDE A COPY FOR YOUR MEDICAL FILE
	EMPLOYER'S NAME						
	STREET ADDRESS			CITY		STATE	ZIP
	HOW MANY INSURANCE PLANS?	ARE YOU RESPONSIBLE FOR FEES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER WHO? _____					
	PRIMARY INSURANCE & POLICY ID			PRIMARY INSURANCE POLICY HOLDER			
	SECONDARY INSURANCE & POLICY ID			SECONDARY INSURANCE POLICY HOLDER			
	EMERGENCY CONTACT LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH	
	PHONE ()		RELATIONSHIP				
	PRIMARY CARE PHYSICIAN & PHONE NUMBER						
	POLICY	It is the policy of FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP to release information to your immediate family and/or leave messages with them or on your answering machine regarding: appointments, lab/tests results, billing, or any other information we feel is necessary to provide quality care for you, unless otherwise stated by you in writing.					
HIPAA	I Have Read, The Health Insurance Portability & Accountability Act of 1996 (HIPAA), and understand my rights. (Purple Sheet) X _____ Date ____/____/____ (Should you desire a copy of this form, please advise the front receptionist.)						

PLEASE GIVE INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY FOR YOUR FILE.

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP to provide whatever treatment they may deem necessary to the patient above

I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy or Medicare, and should it become necessary to collect these charges through an attorney for other collection process, I shall be responsible for all court costs, interest, collection costs, and attorneys fees

I hereby request payment of authorized Medicare benefits and/or any other including supplemental insurance benefits for me to be paid directly to FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP for any services furnished me by FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP I authorize FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP and staff to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided me, needed to determine these benefits payable for related services. I understand this is a lifetime authorization.

Signature of Patient Authorization

Date

Signature of Responsible Person

Date

ADULT MEDICAL HISTORY QUESTIONNAIRE

To be completed at initial establishment visit and yearly thereafter

Patient Name: _____

Today's date: _____ Allergies: _____

What is the main reason you came here today? _____

How did you hear about us? _____

REVIEW OF SYSTEMS Please check **Yes** or **No** for problems that apply to you at the **present** time.

General	YES	NO	Gastro-intestinal	YES	NO	Genitourinary	YES	NO
Normal activity level	_____	_____	Abdominal pain	_____	_____	Urinary frequency	_____	_____
Changes in appetite	_____	_____	Heartburn	_____	_____	Urinary urgency	_____	_____
Weight gain	_____	_____	Regurgitation	_____	_____	Urinary incontinence	_____	_____
Weight loss	_____	_____	Indigestion	_____	_____	Blood in urine	_____	_____
Chills	_____	_____	Nausea	_____	_____	Pain with urination	_____	_____
Fever	_____	_____	Vomiting	_____	_____	Sexual dysfunction	_____	_____
Skin			Change on bowel movement	_____	_____			
Rashes	_____	_____	Change in caliber of stool	_____	_____	Females only		
Sores	_____	_____	Difficulty swallowing	_____	_____	How many children have you had?	_____	
Blisters	_____	_____	Blood in stool	_____	_____	How many times pregnant?	_____	
Growth	_____	_____	Joints and Muscle			Have you ever had a C-section?	_____	
Changing moles	_____	_____	Muscle pain	_____	_____	When was your last period?	_____	
Non healing lesions	_____	_____	Joint pain	_____	_____	Are your periods regular?	_____	
Breast			Muscle weakness	_____	_____	How many days do they last?	_____	
Masses	_____	_____	Joint stiffness	_____	_____	Date of last Pap? _____		
Discharge	_____	_____	Leg cramps	_____	_____	Results: _____		
Skin changes	_____	_____	Pain in legs with walking	_____	_____	Do you have any other medical problems?		
Eyes/ears/nose/mouth/throat			Neuro/Psychological					
Problems with vision	_____	_____	Difficulties in motor strength	_____	_____	Males only		
Eye pain	_____	_____	Difficulties in gait	_____	_____	() enlarged prostate		
Hearing difficulties	_____	_____	Difficulties in memory	_____	_____	() painful or lumpy testicles		
Tinnitus	_____	_____	Difficulties in concentration	_____	_____	() problems with sex		
Vertigo	_____	_____	Changes in mood	_____	_____			
Hoarseness	_____	_____	Tremors	_____	_____			
Swallowing difficulties	_____	_____	Headaches	_____	_____			
Heart and Blood vessels			Dizziness	_____	_____			
Chest pain	_____	_____	Lung					
Chest pressure	_____	_____	Shortness of breath	_____	_____			
Palpitations	_____	_____	Cough	_____	_____			
How many pillows you use to sleep? _____			Wheezing	_____	_____			
Cold extremities	_____	_____						
Feet swelling	_____	_____						

X-RAYS, OTHER TESTS – Please list the last year that any of the following were done.

Tests	Date	Results	Other Tests	Date	Results
_____ Laboratory Test	_____	_____	_____ Cholesterol measurement	_____	_____
_____ Fecal Occult Cards	_____	_____	_____ Cardiac Stress Test (Treadmill)	_____	_____
_____ Colonoscopy	_____	_____	_____ Heart Catheterization	_____	_____
_____ Upper Endoscopy	_____	_____	_____ Dilated Eye examination	_____	_____
_____ CT Scan Abdomen	_____	_____	_____ Dental Examination	_____	_____
_____ Mammogram	_____	_____	_____ Other	_____	_____
_____ DEXA Bone Density	_____	_____			

All Physicians that you are currently under the care of

Physician, Specialty	Office phone number
_____	_____
_____	_____
_____	_____

HOSPITAL AND SURGERY – Please list all hospital admissions, and any other surgeries.

Year	Hospital, city and state	Reason for admission or type of surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MEDICATIONS – Please list all medicines that you use frequently or every day.
Include prescription medicines, aspirin, antacids, vitamins, etc.
and the specialist that prescribes it.**

Medication	Dose	Times/day	Refills left	Specialist
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____

Pharmacy Name: _____ Address: _____

Do you need a 90 day prescription? Yes No

FAMILY HISTORY – Please fill in blanks and check () appropriate items

	Father	Mother	Others	Explain
Colon Cancer				
Breast Cancer				
Other Cancers				
High Blood Pressure				
Heart Problems				
Stroke				
Diabetes				
Kidney Problems				
Osteoporosis				
Sickle Cell				
Seizures, Epilepsy				
Mental Illness				
Depression, Anxiety				
Alcoholism				
Dementia or Alzheimers				

SOCIAL HISTORY – Please circle responses, or fill in blanks

- What is your usual occupation? _____ What kind of work do you do now? _____
- What is the highest grade in school you completed? _____
- Are you? Single Married Divorced Separated Widowed
- Do you exercise? Never Rarely Once a week 3-4 times/week Type of exercise _____
- Do you use tobacco? _____ Cigarettes Cigars Pipe Snuff Chewing tobacco How many packs/day? _____
How many years have you smoked? _____ If you have quit smoking, when? _____
- Do you use alcohol? _____ In a week, how many cans of beer _____ glasses of wine _____ shots of liquor _____
- Do you sometimes use marijuana or other drugs socially? _____
- Are you sexually active? (men, women, or both) _____
- Have there been any unusual stresses in your life in the last year? _____ Broken relationships? _____ Illness/death in the family? _____
Change of Job? _____ Moved? _____ Finances? _____
- Do you use seat belts? _____ Smoke alarms? _____
- Abuse as a child? _____ Physical (hitting) _____
Abuse as an adult? _____ Sexual (unwanted advances) _____
Abuse now? _____ Emotional (yelling, shaming) _____
- Is there anything special you would like to talk about? _____