Florida Heart & Vascular
Multi-Specialty Group

Experience Our Integrity and Compassionate Care

Surgery

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

WELCOME!

All the staff at Florida Heart and Vascular Center would like to take this time to extend a heartfelt welcome to you as a new patient to our practice. We look forward to providing you with the best cardiac care and trained technical staff Florida has to offer. We provide both cardiovascular and peripheral vascular treatment plans using the most sophisticated medical equipment in the area.

Enclosed you will find many papers to fill out which will help expedite your visit with us. It will save you time and you will be able to better fill out these pages in the comfort of your home rather than waiting until the day you come to the office for your first appointment.

Remember these important things on each visit to our office:

- ♥ Bring ALL your medications in a bag to EACH visit.
- ♥ Sign the enclosed “Record Release” form for us to obtain previous records for your cardiac care, especially surgical reports.
- ♥ On EACH visit keep us updated on studies/surgeries you have had since we last saw you, especially if you travel north, try to bring copies of your studies back with you or have them mailed to us.
- ♥ Feel free to call with any questions you may have. We will always do our best to get you the information you need.
- ♥ Visit our website ***www.flheartcenter.com*** for more information.

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.

Once again, **WELCOME** to Florida Heart & Vascular Center. We look forward to your visit with us.

Florida Heart & Vascular Center
Physicians and Staff

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

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

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)

_______History & Physical
_______Discharge Summary
_______Lab Results
_______EKG(s)
_______Echocardiogram Report(s)
_______Chest X-Ray Report(s)
_______Most Recent Office Notes
_______Stress Test Report(s)
_______ Cardiac Catheterization Report(s)
_______Cardiac Catheterization Images
_______Peripheral Ultrasound Report(s)
_______Abdominal Ultrasound Report(s)
_______Carotid Ultrasound Report(s)
_______Peripheral Angiogram Report(s)
_______Peripheral Angiogram Images
_______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

Please Fax Records to (352)728-1743

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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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Multi-Specialty Group

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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 ☐ M ☐ F	SOCIAL SECURITY NO.	MARITAL STATUS	
EMAIL ADDRESS	DO YOU HAVE A LIVING WILL? ☐ YES ☐ 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? ☐YES ☐ NO ☐ 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

GENERAL, THORACIC, AND VASCULAR SURGERY
(352) 728-6904

DAVID L. SUSTARSIC, MD
JONATHAN A. HIGGINS, MD, RPVI

HISTORY & PHYSICAL

PATIENT NAME: ____________ **DOB:** ____________ **AGE:** ____________ **DATE:** ____________

WEIGHT: ____________ **HEIGHT:** ____________ **BP:** ____________ **PULSE:** ____________ **RES:** ____________

REFFERING DOCTOR: ____________

ALL DOCTORS WITH WHOM PATIENT HAS ESTABLISHED RELATIONSHIP

____________ ____________ ____________

____________ ____________ ____________

HISTORY OF PRESENT ILLNESS (HPI):

____

____

____

PAST HOSPITILIZATIONS & 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

GENERAL, THORACIC, AND VASCULAR SURGERY
(352) 728-6904

DAVID L. SUSTARSIC, MD
JONATHAN A. HIGGINS, MD, RPVI

HISTORY & PHYSICAL - TO BE COMPLETED BY PATIENT

PATIENT NAME: ______________________________ **DATE:** ____________

CURRENT MEDICATIONS:

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

ALLERGIES:

____

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

CONSTITUTIONAL	YES	NO	**EAR/NOSE/MOUTH/THROAT**	YES	NO	**EYES**	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
CARDIOVASCULAR	YES	NO	**RESPIRATORY**	YES	NO	**GASTROINTESTINAL**	YES	NO
Chest Pain	Y	N	Shortness of Breath	Y	N	Nausea/Vomiting	Y	N
Palpitations	Y	N	Cough	Y	N	Abdominal Pain	Y	N
Heart Trouble	Y	N	Wheezing/ Asthma	Y	N	Rectal Bleeding	Y	N
Swelling Hands/ Feet	Y	N	Coughing Up Blood	Y	N	Bowel Problems	Y	N
MUSCULOSKELETAL	YES	NO	**NEUROLOGICAL**	YES	NO	**SKIN/BREAST**	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 Paint	Y	N	Convulsion/Seizures	Y	N	Breast Lump	Y	N
Trouble Walking	Y	N	Numbness/ Tingling	Y	N	Breast Pain or Discharge	Y	N
ENDOCRINE	YES	NO	**HEMATOLOGIC/LYMPHATIC**	YES	NO	**ALLERGIC/IMMUNOLOGIC**	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
GENITOURINARY-MALE	YES	NO	**GENITOURINARY-FEMALE**	YES	NO	**PSYCHIATRIC**	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 Loss	Y	N
Sexual Problems	Y	N	Sexual Problems	Y	N	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 day
Alcohol Use:	Never	Rarely	Moderate	Daily	How Much?__________
Drug Use:	Never	Type & Frequency______________________________			

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

Signature: ______________________________ Date: ____________________