Leonard Pianko, MD
AVENTURA CARDIOVASCULAR CENTER

Patient History Form

REGISTRATION FORM

Patient Information

Date: _____

Name: _____ I prefer to be called: _____

Address: _____Apt#_____City:_____State:_____Zip_____

Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race

Primary Language: _____

Email address: _____

The best time to contact me is: _____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Care Provider: _____ Phone: _____

Spouse or Parent's Name: _____

Patient's Employer_____ Phone_____

Whom may we thank for referring you? _____

Emergency Contact: _____ Relationship to patient: _____Phone_____

Responsible Party (If other than the patient)

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other _____

Name: _____ DOB: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer_____ Phone (____)_____ SSN#_____

********** INSURANCE AUTHORIZATION **********

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries, or carrier, any information needed for this or related Medicare claim. I authorize the release of any medical information necessary to other insurance carriers in order to process any other claims. I also authorize payment of medical benefits to Leonard J. Pianko, M.D., P.A., or to any of his associates.

➔Patient's Signature: _____ Date: _____

I understand that I am financially responsible for payment of my medical services to Leonard J. Pianko M.D., P.A., regardless of any insurance benefits that I might have, and understand that it is my responsibility to collect any reimbursement from my insurance company. I understand that I will be responsible for any fees that might be incurred by Leonard J. Pianko, M.D., P.A. in his efforts to collect fees due him, including fees from collection agencies, attorney's fees and court costs.

➔Patient's Signature: _____ Date: _____

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Current Medications

Name	Strength	Frequency	Name	Strength	Frequency

ALLERGIES: _____

PHARMACY: **NAME:** _____ **PH:** (_____) _____-_____

Medical History

Diagnosis	Year	Diagnosis	Year

Surgical History

_____
_____
_____
_____
_____
_____

Hospitalization

Reason	Hospital	Location	Date

Patient's Name: _____ Date: _____ Physician's Initials: _____

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Family History

Father: ☐ Alive ☐ Deceased
Medical History:
☐ Cancer
Type _____
☐ Heart Disease
☐ Hypertension
☐ Stroke
☐ High Cholesterol
☐ Other: _____

Mother: ☐ Alive ☐ Deceased
Medical History:
☐ Cancer
Type _____
☐ Heart Disease
☐ Hypertension
☐ Stroke
☐ High Cholesterol
Other: _____

Siblings: ☐ Alive ☐ Deceased
Medical History:
☐ Cancer
Type _____
☐ Heart Disease
☐ Hypertension
☐ Stroke
☐ High Cholesterol
Other: _____

Social History

Tobacco

☐ Yes ☐ No ☐ Former
Type: _____
Year Quit: _____
Packs/Day: _____
Years Smoked: _____

Alcohol

☐Yes ☐No
☐ Social
☐ Daily
☐ Weekend

Exercise

☐ Sedentary
☐ Occasional
☐ Regular

Illicit Drug Use

☐ Yes ☐ No
Type of drug: _____

Patient's Name: _____ Date: _____ Physician's Initials: _____

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Patient Agreement to Pay for Medical Services

I hereby authorize Leonard J. Pianko, M.D., F.A.C.C., to furnish my insurance carrier all information concerning my illness. I also authorize benefits under this claim to be made payable directly to the physician. I understand that I am responsible financially to the physician for charges no covered by my insurance company, I, the patient or the guardian of the patient, will be responsible in full in payment.

I also understand that all co-payments and / or deductibles are to be paid at the time services are rendered. I also understand that physician charges may occur if I am in the hospital and I will be responsible for those charges as well. I agree to assist Leonard J. Pianko, M.D., F.A.C.C. in any collection efforts to receive payment from my insurance company providing the office with any information that may be necessary for the physician to receive payment.

I understand that by signing this agreement I agree to make all payments to Leonard J. Pianko, M.D., F.A.C.C. that I am responsible for and that if the insurance denies a claim for any reason that I am responsible ultimately for payment in full to the physician.

By not signing this agreement, services may be denied.

➔Signature: _____ Date: _____

Print: _____ Date: _____

Guardian signature (if patient is not competent)

Please give the receptionist your insurance card and driver's license to be photocopied.

Thank you.

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in the place of the original.

➔Signature: _____ Date: _____

I hereby authorize Leonard J. Pianko, M.D., F.A.C.C, to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Leonard J. Pianko, M.D., F.A.C.C. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

➔Signature: _____ Date: _____

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AVENTURA CARDIOVASCULAR CENTER

Patient History Form

Consent to Medical Care

Please Read This Form Carefully and Completely Before Signing It

I authorize Leonard J. Pianko, M.D., F.A.C.C. to determine what kinds of diagnostic procedures (tests) must be done in order to treat me. These may include x-rays, blood tests, urine analysis, blood pressure tests or other routine tests. I understand that if my doctor advises a more complex test, or one which has special risks, that it will be explained to me. Further, I authorize the personnel of Leonard J. Pianko, M.D., F.A.C.C. to assist in giving, or to give, the tests which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and to perform such procedures as he may deem them necessary, in his professional judgment, to preserve my health.
Additionally, I authorize the personnel of Leonard J. Pianko, M.D., F.A.C.C. to assist in the giving or to give, the therapy which my doctor will order. I fully understand that medical tests or treatments may involve certain unavoidable risks.

If part of my treatment is very complex or carries special risks, it will be explained to me.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment which I might receive. However, I acknowledge that my doctor is available to answer any questions I might have. I understand that the practice of medicine and surgery are not exact sciences and acknowledge that no guarantee or assurance has been made to me as to the results of treatments or examination.

I certify that I have read this form, and had it explained to me, and I certify that I fully understand its contents.

_____ _____

➔**Patient Signature** **Date**

FOR PATIENTS UNABLE TO SIGN

_____ _____

Signature of Legal Representative **Date**

Advanced Directives

A living will is a document that advises your family and physician of your desires should you become unable to make decisions regarding your healthcare. A healthcare surrogate is a person that you designate to make decisions for your healthcare in the event that you are unable to. If you have prepared these documents, please give a copy to your doctor to be included in your chart.

_____ _____ _____

Patient's Name Date ➔**Patient's Signature**

_____ _____ _____

Witness Name Date Witness Signature

I have signed an Advance Directive _____ Yes _____ No

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HIPPA
(HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)
EFFECTIVE APRIL 9, 2003

Due to new federal and state mandates, please note the following important information.

Leonard J. Pianko, M.D., F.A.C.C. is committed to maintaining and protecting the confidentiality of our patients' personal and confidential information. We are required by federal and state law to protect the privacy of our patients' health and personal information. Therefore, we have instituted the following changes to ensure compliance with these laws.

We are no longer permitted to leave detailed messages on an answering machine or with family members. We must speak directly with the patient.

In order for any personal information to be given out to any other person(s) other than the patient the following release must be filled out: **Please initial next to the option(s) you choose.**

1) I, _____, authorize Leonard J. Pianko, M.D., F.A.C.C., to release my medical information and will accept responsibility for the loss of privacy. You may leave a message for me at my contact number on file.
2) I authorize release of any and all of my medical information, whether verbally or in writing, to the following person(s):

Name:	**Relationship:**
_____	_____
_____	_____

_____ _____

Patient Name ➔**Signature**

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AVENTURA CARDIOVASCULAR CENTER

Patient History Form

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____

Telephone: ( ) _____

SECTION B: To the Patient – Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Out notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Leonard J. Pianko, M.D., F.A.C.C. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:
I, _____, have had full opportunity to read your Notice of Privacy Practices posted in your waiting room. I understand that, by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

➔**Signature:** _____ Date: _____

I consent permission to view my prescription listing from external sources _____

➔**Initial**

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Patient History Form

Medical Records Release Form

Today's Date: _____

Check as appropriate:

__X__ All progress notes for the past 3 months

__X__ All laboratory tests for the past 12 months

__X__ All consultation, emergency room and hospital reports, including but not limited to inpatient and outpatient reports, inpatient history and physicals, and inpatient discharge summaries for the past 24 months.

__X__ All EKG's and imaging reports including, but not limited to, surgery, colonoscopy, bronchoscopy, endoscopy, biopsy, cardiac catheterization , and interventional radiology irrespective of the date of the procedure.

Patient Name (Printed) _____

Date of Birth _____ Last 4-digits of Social xxx-xx-_____

Signature _____ Date: _____

Witness _____ Date: _____

Get Records From:

Dr/Facility: _____

Phone: _____

Fax: _____

Send Records To:

Leonard J. Pianko, M.D., F.A.C.C.

Fax: 305-933-1749

Phone: 305-932-2441