

# IBRAHIM

HEART CLINIC

5150 BELFORT RD. BLDG. 400 | JACKSONVILLE, FL 32256

## New Patient Intake

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

### PATIENT INFORMATION

Name: \_\_\_\_\_ SSN#: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female  Prefer Not to Answer Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Party (if dependent): \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### PRIMARY INSURANCE

Insurance Name: \_\_\_\_\_ Type (PPO, HMO, EPO): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Name: \_\_\_\_\_ Type (PPO, HMO, EPO): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### CANCELLATION POLICY

I understand that Ibrahim Heart Clinic will charge a **FEE OF \$35** for appointments canceled or missed without 72 hours advance notice.

SIGNED: \_\_\_\_\_

### PAYMENT POLICY

I understand that regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Ibrahim Heart Clinic. I understand that Ibrahim Heart Clinic will submit insurance claims, however, insurance payment for submitted claims is not guaranteed.

SIGNED: \_\_\_\_\_

# Review of Symptoms

CHECK BOX IF APPLICABLE

<b>Systemic Symptoms</b>	<input type="checkbox"/> Feeling Fatigued	<input type="checkbox"/> Fever	<input type="checkbox"/> Recent Weight Loss					
<b>Head Symptoms</b>	<input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Headache						
<b>Eye Symptoms</b>	<input type="checkbox"/> Worsening Vision	<input type="checkbox"/> Floaters in Visual Field	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Blurry Vision				
<b>ENT Symptoms</b>	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Mouth Dryness			
<b>Cardiovascular</b>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Leg Pain with Exercise	<input type="checkbox"/> Slow Heart Rate	<input type="checkbox"/> Fast Heart Rate			
<b>Pulmonary Symptoms</b>	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Awakening at Night Short of Breath	<input type="checkbox"/> Orthopnea	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Wheezing	
<b>GI Symptoms</b>	<input type="checkbox"/> No Appetite	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Bright Red Blood Per Rectum	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	
<b>GU Symptoms</b>	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Change in Urinary Frequency	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Excess Night Urination	<input type="checkbox"/> Urinary Urgency	<input type="checkbox"/> Urinary Incontinence	<input type="checkbox"/> Male Erectile Dysfunction	
<b>Endocrine Symptoms</b>	<input type="checkbox"/> Flushing	<input type="checkbox"/> Sweating Heavily at Night	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Feeling of Weakness	<input type="checkbox"/> Change in Libido	
<b>Musculoskeletal</b>	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Muscle Aches	<input type="checkbox"/> Arthralgias	<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Joint Pain Localized to One or More Joints	<input type="checkbox"/> Joint Swelling Localized to One or More Joints	<input type="checkbox"/> Localized Joint	
<b>Neurological</b>	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Fainting	<input type="checkbox"/> Confusion	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Difficulty with Balance	<input type="checkbox"/> Tingling	<input type="checkbox"/> Numbness
<b>Psychological</b>	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depressed	<input type="checkbox"/> Sleep					
<b>Skin Symptoms</b>	<input type="checkbox"/> Localized Skin Discoloration	<input type="checkbox"/> Rash						

Drug Allergies: \_\_\_\_\_ List of Surgeries: \_\_\_\_\_

Years of Smoking: \_\_\_\_\_ Quantity of Weekly Alcohol: \_\_\_\_\_

List of Established Diagnoses: \_\_\_\_\_

Relevant Family History: \_\_\_\_\_



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## Sleep Evaluation

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

Name: \_\_\_\_\_ SSN#: \_\_\_\_\_

Email: \_\_\_\_\_

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

### RATE THE BELOW SITUATIONS USING THE FOLLOWING SCALE

- 0** Would never doze or sleep
- 1** Slight chance of dozing or sleeping
- 2** Moderate chance of dozing or sleeping
- 3** High chance of dozing or sleeping

Situation	Chance of Dozing (0 - 3)
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch, without alcohol	
In a car, while stopped for a few minutes in traffic	
<b>TOTAL</b>	

### DO YOU HAVE? (CHECK ALL THAT APPLY)

- High Blood Pressure
- Diabetes
- Heart Disease
- None of the Above
- Atrial Fibrillation
- Lung Disease
- Suffered a Stroke

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## Acceptance of Financial Liability

Ibrahim Heart Clinic will bill your insurance company (primary and secondary) for services rendered as a courtesy. Please be aware that you are ultimately responsible for all charges for services rendered. In the event services rendered are not covered by your insurance company, we will require that you remit payment to this office. Additionally, if your insurance company does not remit payment in a timely manner after rebilling the claim or appealing the claim within 60 days from the time your claim was billed, we will transfer the balance to your responsibility and require that you remit payment to this office for all outstanding insurance balances over 60 days. The outstanding balances may include, but limited to:

- **Office visit co-payments**
- **Annual deductibles**
- **Share of costs**
- **Non-covered services**

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that may be provided to you. As a courtesy, we will contact your insurance company for authorization for these services, however, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services rendered, preventing delays in treatment and expedite payment. Insurance companies are more responsive when they are contacted by their policyholders, however, our billing office is always available to assist in this undertaking.

### **CO-PAYMENTS**

Co-pays are required at the time of your appointment.

### **RESCHEDULED / MISSED APPOINTMENTS**

Please contact our office at least 72 hours in advance of your scheduled appointment time if you need to reschedule. Please be advised that a \$35 charge will apply to no-shows or last-minute cancellations if made within a 72-hour window. Your cooperation in adhering to these guidelines plays a vital role in the streamlining of care for everyone involved.

### **DEDUCTIBLES**

If you have not met your deductible for your plan year, you will be required to pay your share of cost of your medical services at the time of your scheduled appointment.

### **INSURANCE CARDS**

You must present your insurance card at each visit to our office.

Yours in health,

**Ibrahim Heart Clinic**

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## Records Release

### MEDICAL RECORDS RELEASE & AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: \_\_\_\_\_ SSN#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information:

- **All records; Laboratory/pathology records; X-ray/radiology records**
- **Billing records; Abstract/summary**
- **Pharmacy/prescription records**
- **Other (describe specifically):** \_\_\_\_\_

**\*Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information. These records are for services provided on the following date(s): \_\_\_\_\_

Please send the records listed above to: \_\_\_\_\_

The information may be used/disclosed for each of the following purposes: \_\_\_\_\_

For my health care, payment/insurance, employment purposes; Other: \_\_\_\_\_

**Ibrahim Heart Clinic**  
**5150 Belfort Rd. Bldg. 400**  
**Jacksonville, FL 32256**

This authorization shall expire no later than: \_\_\_\_\_ or upon the following event \_\_\_\_\_ (whichever is sooner), and may not be valid for great than one year from the date of signature for Ibrahim Heart Clinic medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

\_\_\_\_\_  
Signature of patient (or patient's representative)

*Printed name of patient representative Representative's authority to sign for patient, (i.e.: parent, guardian, power of attorney for healthcare, executor)*

*You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy liaison, Stephanie Fasulo, 5150 Belfort Rd. Bldg. 400, Jacksonville, FL 32256.*