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

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

Medication List: _____ Drug Allergies: _____

List of Surgeries: _____ List of Established Diagnoses: _____

Quantity of Weekly Alcohol: _____ Years of Smoking: _____

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	
TOTAL	

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.