Abdul Kani, M.D.
General & Interventional Cardiology
8245 Bayberry Rd. Jacksonville, Fl 32256
Ph:(904)296-7775 Fax:(904)296-7760

Patient Information

In order for us to provide you with the best possible care, please fill out these forms as completely and accurately as possible.

Last Name: _____ First Name: _____Middle Initial: ____
Mailing Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Home Phone: _____ Email: _____
Date of Birth: _____ Age: ____ Social Security Number: _____
Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name: _____ Phone: _____
Spouse's Employer: _____ Work Phone: _____
Education (optional): ☐ High School ☐ Associate Degree ☐ College ☐ Post Graduate
Race (optional): ☐ Caucasian/White ☐ Black American ☐ American Indian ☐ Asian
☐ Pacific Islander ☐ Hispanic ☐ Other: _____
Ethnic Group (optional): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone number: _____
Address: _____

Employer Information

Occupation: _____ Employer: _____
Work Phone: _____ Fax Number: _____

Primary Care Physician (PCP)

Doctor's Name: _____ Facility: _____
Phone number: _____ Fax number: _____

Referring Physician (if different from PCP)

Doctor's Name: _____ Specialty: _____
Phone number: _____ Fax number: _____

Emergency Contact

Name: _____ Relationship: _____
Home/Cellphone: _____ Work Phone: _____
Address (if different from above): _____

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Insurance Information

Kindly give your insurance card and ID to the receptionist

Primary Insurance Carrier: _____ Phone: _____
Policy #: _____ Group #:_____
Subscriber's Name: _____
Subscriber's birthdate: _____ Subscriber's Social Security #: _____
Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other: _____

Secondary Insurance Carrier: _____ Phone: _____
Policy #: _____ Group #:_____
Subscriber's Name: _____
Subscriber's birthdate: _____ Subscriber's Social Security #: _____
Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other: _____

Payment Information

Person Responsible for Bill: _____
Relationship to Patient: _____
Address (if different): _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

INSURANCE AUTHORIZATION

I authorize the release of medical information necessary to process the insurance claim(s). I authorize and direct my insurance carrier or intermediaries to issue payment check(s) directly to **North Florida Multispecialty Physicians, LLC** who rendered services at the office. I understand that my insurance company may require an authorization number, precertification and/or referral. Without this documentation, I understand that my insurance may deny benefits. If my insurance company denies payment for service(s) rendered by **North Florida Multispecialty Physicians, LLC** who rendered services at the office **I AGREE TO BE RESPONSIBLE FOR THE PAYMENT OF THE SERVICES RENDERED**. I understand that I am responsible for any amount not covered by my insurance such as but not limited to deductible and co-insurance. I further understand that **North Florida Multispecialty Physicians, LLC** cannot accept responsibility for collection of my claims or for negotiating a settlement on a disputed claim once your claim goes to a collection company for non-payment.
The undersigned acknowledges that all information provided is true and accurate.

Patient Signature: _____ **Date: _____**

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Assignment of Benefits

Patient: _____

Employer: _____

Social Security Number/ ID Number: _____

For Third Party Payers ONLY

I hereby instruct and direct_____ to pay by check made out and mailed to North Florida Multispecialty Physicians, LLC.

OR

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:_____

_____

For the professional or medical expense benefits allowable and otherwise payable to me under my insurance policy as payment toward the total charges for the professional services rendered. THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness which may include my patient responsibility as mentioned by my payer via the EOB. This may include copayment, deductibles, and co-insurance amount. A photocopy of this Assignment shall be considered as effective as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____ Date: _____Time: _____

Witness: _____ Date: _____ Time: _____

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Notice of Privacy Practices Receipt

Patient Name: _____ Date of Birth: _____

I hereby give authorization to **North Florida Multispecialty Physicians, LLC** for the release of information concerning the status of my healthcare, including but not limited to results of laboratory and radiology tests and to discuss my plan of treatment with the names listed below:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

I understand that I may revoke this authorization at any time, with written notice.

Signature: _____ Date: _____

For Personal Representative of the Patient

(Only applies if the patient has someone that have power of attorney over him/her)

Print Name of personal representative: _____

Signature of personal representative: _____

I acknowledge that I was provided with the Notice of Privacy Practices provided by North Florida Multispecialty Physicians.

Signature of Patient: _____ Date: _____

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REQUEST FOR RELEASE OF RECORDS

To:

_____

Name of Doctor/Hospital/Medical Facility

You are hereby authorized and requested to furnish any and all medical information, including but not limited to medical/cardiovascular reports, laboratory results and any imaging like X-rays, Ultrasounds, CT scans or PET scans to **North Florida Multispecialty Physicians, LLC** at 8245 Bayberry Rd. Jacksonville, FL 32256. With respect to any injury, disease or condition pertaining to my physical or mental condition in the past, present or future. A photocopy of this authorization should be likewise honorable.

Date: _____

Patient's Name (Print): _____

Date of Birth: _____ Social Security Number#: _____-_____-_____

Patient's Signature: _____

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Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____

Current Medications:

***Please remember to bring all medications with you on your appointments.**

Please list all medications (prescription and non-prescription) that you are now taking or occasionally take:

Medication Name	Dosage	Frequency	Prescriber/Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History:

Please check if you have had any of the following problems in the past:

__ High Blood Pressure	__Congestive Heart Failure	__ Arm pain/Jaw Pain
__ Chest pain/Pressure	__ Heart Valve Disease	__ Dizziness
__ Shortness of breath	__ Abnormal EKG	__ Headaches
__ Type1 Diabetes Mellitus	__ Heart Murmur	__ Sleep Apnea
__ Type2 Diabetes Mellitus	__ Palpitations	__ COPD
__ Hyperlipidemia	__ Irregular Heart Beat	__ Blood clots in lungs
__ Strokes/Heart Attack	__ Blackouts/fainting spells	__ Blood clots in veins/legs

Others heart related problems: _____

_____

_____

Current Allergies:

Do you have ALLERGIES to iodine, seafood, or radiographic contrast dye?: Yes ☐ No ☐

Please list ANY other allergies and describe the reaction:

Allergy to: **Reaction**(Rash/Swelling/Itching/Difficulty Breathing or Swallowing):

1. _____-_____
2. _____-_____
3. _____-_____
4. _____-_____
5. _____-_____

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Past Cardiac Procedures or Tests:	**Date**	**Location**	**Physician**
Heart Catheterization (dye test)	_____	_____	_____
Heart Surgery (bypass/valve replace)	_____	_____	_____
Heart Stent/Angioplasty	_____	_____	_____
Pacemaker or ICD implantation	_____	_____	_____
Echocardiogram or Carotid Scan	_____	_____	_____
Stress Test (treadmill or nuclear)	_____	_____	_____
Holter Monitor	_____	_____	_____
Electrophysiology Study	_____	_____	_____

Other: _____

_____

Past Surgeries: (Please provide date/year if any applies)

Gallbladder removal _____ Hysterectomy _____ Appendix Removal _____

Tonsillectomy _____ Breast Biopsy/Mastectomy _____

Other: _____

_____

Hospitalizations: (List any serious illness that lead to a hospitalization, please include date)

_____

_____

_____

Family History: Please list any parents, brothers, sisters and/or children who have had a heart attack, stroke, angioplasty, heart disease, cardiac arrest, blackout spells or vascular disease.

Relationship: _____ Condition: _____ At what age: ___ Deceased? Y/N

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Relationship: _____ Condition: _____ At what age: ___ Deceased? Y/N

Relationship: _____ Condition: _____ At what age: ___ Deceased? Y/N

Other: _____

_____

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Social History and Lifestyle:

Do you currently smoke? Yes☐ No☐ If yes, how much do you smoke? _____
How long have you been smoking? _____ If you quit, when did you quit? _____
Do you drink alcohol? Yes☐ No☐ If yes, how often? _____
How many drinks on an average day? _____
Do you drink anything with caffeine (coffee, tea, soda, chocolate)? Yes☐ No☐
How much do you drink in a day? _____
Do you have a history of drug dependency? Yes☐ No☐ If yes, please specify? _____
_____

LEG VEIN SCREENING (Kindly check any that ***apply*** in one or both of your legs)

Aching/ Leg pain:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐
Heaviness:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐
Varicose veins/Bulging:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐
Tiredness/Fatigue:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐
Itching/Burning:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐
Leg swelling/Edema:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐
Leg cramps/Throbbing:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐
Restless Legs:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐
Non-healing wounds/Ulcers:	Yes☐ No☐	If yes: Right Leg☐	Left Leg☐

Thank you for taking time to fill-up this form, and as a reminder, we would recommend that you bring *all* your medications and any *recent* records/notes from your other doctors/hospitals in each appointment.

Signature of Patient: _____ Date: _____

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PATIENT FINANCIAL POLICY

Self-Pay Patients

Any Self-Pay (no insurance coverage) patient must pay corresponding fees for initial visit, cardiac tests (EKG, Echocardiogram, Carotid scan, stress test, etc.) and follow up appointments. Please ask front desk for more information.

Fees

Due to the rising practice expenses and the demands on our staff of increasing paperwork and telephone calls, it has become necessary to institute the following charges.

Missed Appointments without 24 business hour notice……$50.00
Missed Nuclear Stress test without 48 business hour notice……$300.00
Missed PET Stress test without 48 business hour notice……$500.00
Missed Vein Ablation Procedure without 48 business hour notice……$300.00
Missed Cardiac Testing……$150.00
(Echocardiogram, Regular Treadmill, Venous duplex, Carotid Duplex, ABI, etc.)

Form Fees (Outside of office visit)

Disability……$35.00
Life Insurance……$35.00
Typed Letters (for any reason)……$25.00
FMLA……$35.00
Medical Records (for patients, insurance companies, lawyers, etc.)
$1 per page for the first 25 pages then $0.25 per page thereafter.

Returned Check Fees

Returned Checks (NSF policy) – If a check is returned to **North Florida Multispecialty Physicians, LLC for insufficient funds,** a $35 fee will be added. The patient is required to bring in the appropriate amount of cash to cover the returned check plus additional fees.
Once you have had a returned check fee applied to your account, we will no longer be able to accept personal checks. You will be required to pay with cash or money order.

Please note that charges/fees listed above might be subject to change without prior notice. If you have any questions on any part of this document feel free to approach the front desk. Thank you.

Patient Name: _____ **Signature:_____**