



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 #: _____

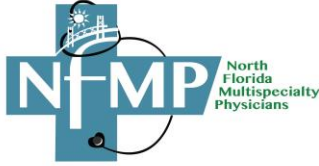
City: _____ State: _____ Zip Code: _____

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: _____

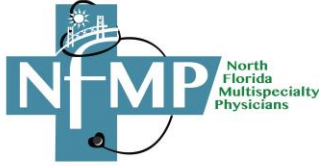
For the professional or medical expense benefits allowable and otherwise payable to me under my insurance policy as payment toward the total charges for the professional services rendered. THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Arm pain/Jaw Pain |
| <input type="checkbox"/> Chest pain/Pressure | <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Type1 Diabetes Mellitus | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Type2 Diabetes Mellitus | <input type="checkbox"/> Palpitations | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Blood clots in lungs |
| <input type="checkbox"/> Strokes/Heart Attack | <input type="checkbox"/> Blackouts/fainting spells | <input type="checkbox"/> 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

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: _____