



**The Heart
& Vascular
Center**

OF SARASOTA

Welcome to The Heart & Vascular Center Of Sarasota!

We are delighted you have chosen us as your medical provider.

In an effort to make your first visit as productive as possible, we are providing a number of documents for you to review, complete and sign in preparation for your appointment.

Please complete and return the following forms prior to your appointment:

1. *Authorization to Use and Disclose Health Information* (please include your primary care physician, previous cardiologist and any hospitals you had cardiac procedures at)
2. *List of all Doctors currently treating you, both in Florida and other states (please provide their address , phone and fax if possible)*

In addition, please bring the following items to your first appointment:

1. Photo ID
2. Insurance Cards and Prescription Cards (if applicable)
3. List of all current Medications and Dosages (including OTC supplements)
4. Remaining New Patient Forms

Visit our website at **www.heartcenter.com**

Please do not hesitate to ask if you have any questions.

Sincerely,

Heart & Vascular Center of Sarasota



Clayton E. Bredlau, M.D., FACC

Dr. Bredlau, a native of Schenectady, NY, is an interventional cardiologist who has been practicing cardiology in Sarasota, Florida since 1986.

He graduated cum laude from Harvard University and received his medical degree from the University Of Cincinnati School Of Medicine. He completed three years of internal medicine training at the Albany Medical Center in Albany, NY.

Dr. Bredlau then moved to Atlanta, where he undertook a 4 year cardiology fellowship at Emory University, which included one year of specialized training in coronary angioplasty with Dr. Andreas Gruentzig, the physician who invented angioplasty.

In his practice, Dr. Bredlau provides every patient with individual and compassionate care and focuses on preventative care, while offering comprehensive testing facilities including a nuclear stress lab, echo lab as well as vascular lab, which allows him to fully evaluate each patient's cardiovascular status.

Dr. Bredlau is one of the most experienced interventional cardiologists in Southwest Florida, having performed thousands of cardiac catheterizations and highly complex angioplasties (balloon angioplasty, rotational and laser atherectomy and brachytherapy) and stent placements. He performs coronary, renal and peripheral artery procedures.

He and his staff regularly attend seminars and conferences in order to stay abreast of new developments in the field of Cardiology.

Dr. Bredlau has hospital privileges at Sarasota Memorial Hospital, where he rounds on his patients daily, as well as Doctor's Hospital.

Dr. Bredlau is married to Annegret, who is also the Practice Administrator, and they are parents to a young daughter. He enjoys reading, walking, travelling, dancing, skiing and watching his favorite football team, the Tampa Bay Bucs.

Dr. Bredlau is board certified in Internal Medicine, Cardiovascular Diseases and Interventional Cardiology; he is a fellow of the American College of Cardiology and a member of the American College of Physicians, the American Heart Association, the American Medical Association and the American College of Physicians.

Patient Medical/Family History

Patient Name _____ **DOB** _____ **SSN** _____

(Full legal name)

Do you have Allergies? Y _____ N _____ **If yes, please list** _____

PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING (NAME, DOSAGE/STRENGTH, &FREQUENCY)

Name _____	Strength/Dosage _____	How Often Taken _____
Name _____	Strength/Dosage _____	How Often Taken _____
Name _____	Strength/Dosage _____	How Often Taken _____
Name _____	Strength/Dosage _____	How Often Taken _____
Name _____	Strength/Dosage _____	How Often Taken _____

PLEASE LIST ALL YOUR SURGICAL PROCEDURES

Procedure _____	Year _____	Procedure _____	Year _____
Procedure _____	Year _____	Procedure _____	Year _____
Procedure _____	Year _____	Procedure _____	Year _____

Have you ever had: Circle one

Skin Cancer Yes No

Malignant Melanoma Yes No

Anemia Yes No

Gout Yes No

Stroke Yes No

Breathing Difficulties Yes No

Palpitations Yes No

Heart Murmur Yes No

Abnormal EKG Yes No

Rheumatic Fever Yes No

High Blood Pressure Yes No

Angina Yes No

Heart Attack Yes No

Hiatal Hernia Yes No

Arthritis Yes No

Gallbladder problems Yes No

Thyroid problems Yes No

Kidney problems Yes No

Ulcers Yes No

Bowel problems Yes No

Psychiatric problems Yes No

Liver problems Yes No

Other (please specify) Yes No

Have you ever had: Circle one

Diabetes Yes No **Controlled by:** _____

High Cholesterol Yes No **Count / When** _____

Do you currently use tobacco? Yes _____ No _____

Circle one or more: Cigars Cigarettes Pipe Chewing tobacco

Have you ever used tobacco? Yes _____ No _____

Circle one or more: Cigars Cigarettes Pipe Chewing tobacco

How many years? _____ **How much per day?** _____

When did you quit? _____

Please estimate your daily consumption of alcohol _____

Is there anything else we should know about your health or historical background? _____

Family History

Father Living Yes No **Age or Age at Death** _____ **Cause of Death** _____

Mother Living Yes No **Age or Age at Death** _____ **Cause of Death** _____

How Many Brothers? _____ **Number Living** _____ **Number Deceased** _____ **Age&Cause of Death** _____

How Many Sisters? _____ **Number Living** _____ **Number Deceased** _____ **Age&Cause of Death** _____

How Many Children? _____ **Ages:** _____ **Any Health problems?** _____

If yes, of what nature? _____

How Many Grandchildren _____

Do any of the following illnesses run in your family?

Skin Cancer	Yes No	Which Member:	_____
Malignant Melanoma	Yes No	Which Member:	_____
Diabetes	Yes No	Which Member?	_____
Stroke	Yes No	Which Member?	_____
Hypertension	Yes No	Which Member?	_____
Heart Disease	Yes No	Which Member?	_____



1217 S. EAST AVE, SUITE 104, SARASOTA, FL 34239

WWW.HEARTCENTER.COM

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE READ AND COMPLETE THE ENTIRE FORM.

PATIENT NAME: _____

PATIENT ADDRESS: _____

DATE OF BIRTH: _____

SOCIAL SECURITY: _____

TELEPHONE NO.: _____

EMAIL: _____

I authorize the Heart & Vascular Center of Sarasota to use and disclose a copy of the specific health and medical information described below:

() Send my records to:

() Obtain my records from:

Name of Physician or Facility

Complete Street Address

City

State

Zip Code

Telephone/Fax No.

Purpose: () Continued Medical Care () Personal Use () New Patient Appt. on: _____

List specifically the information to be released:

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and,
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request. A photocopy of this authorization shall have the same affect as the original.

I understand that my record may contain information about alcohol and/or drug treatment, mental health or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above.

I understand the Heart & Vascular Center of Sarasota may utilize a medical records correspondence service and that there may be a fee assessed for this service.

PLEASE ALLOW 7 TO 10 BUSINESS DAYS FOR RECORDS TO BE COPIED.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Signature of Patient/Legal Representative	Relationship to Patient	Date

COST OF REPRODUCING MEDICAL RECORDS

64B8-10.003 Costs of Reproducing Medical Records:

1. Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records
2. Reasonable cost of reproducing copies of written or typed documents or reports shall not be more that the following:
 - a) For the first 25 pages, the cost shall be \$1.00 per page.
 - b) For each page in excess of 25 pages, the cost shall be 25 cents.
3. Reasonable costs of reproducing X-rays, and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

The Heart & Vascular Center Of Sarasota * Ph: 941-365-0433 * Fax: 941-954-2064

Credit(s):

Specific Authority 458.309 FS. Law Implemented 455.674, 455.677, 458.331 (1) FS. History – New 11/17/87, Amended 5/12/88, Formerly 21M-26.003, 61f6-26.003, 59r-10.003.

PATIENT FINANCIAL POLICY

Date: _____

Account# _____

Patient Name: _____ DOB: _____

Dear Patient:

Thank you for choosing The Heart and Vascular Center of Sarasota, Inc. (HVCS) as your healthcare provider. We are committed to providing you the highest quality, most affordable healthcare service available. In order to do so, we have established the following Financial Policy which we request that you read, agree to and sign before services are provided. A copy will be provided to you upon request.

It is the policy of HVCS to help keep your health care costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- √ Always bring your current health insurance card to the office.
- √ Please notify us prior to your appointment of any changes to insurance, address, telephone or family status.
- √ Please pay your co-pay, balances or deductible at the time of service.
- √ You will be expected to pay in full if:
 - You do not have insurance;
 - HVCS does not participate with your health plan;
 - You are unable to present a valid member identification card from your insurance carrier at your visit;
 - We are unable to verify your insurance coverage;
 - You have a pre-existing condition or other diagnosis that may not be covered by your plan;
 - You have not met the deductible under your health plan contract or
 - Routine services may not be covered by some insurance plans.
- √ You should receive a bill for any charges that are your responsibility within 30 days of service; and/or an explanation of benefits (EOB) from your insurance company. If you have any questions about your bill, please contact our billing office at 941- 379-7872 option 1. Please provide your name, physician in reference, phone number to the service and someone from the billing office will return your call within 48 hours.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.

Payment Options if you have Insurance: We are required by our insurance contracts to collect all copays and other patient responsible amounts, at the time of service. To assist you, we accept cash, checks or credit/debit cards.

It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, we suggest that you verify coverage limitations prior to being treated.

If your insurance company has not processed your account within 90 days from the date of service, the balance will automatically be sent to you. Your signature on this form indicates that you authorize HVCS to bill your insurance company directly for services rendered and for your insurance company to make payment directly to HVCS.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs including a collections fee that may be added to the account.

Patient Financial Policy Continued:

If we need to send the account balance to collection because of non-payment of the account, our physicians may no longer be able to provide care. In this case, the person responsible for the account will be notified of this by certified mail and given adequate time to find a new medical provider.

All accounts sent to the collection agency will be reported to the Credit Bureaus.

Returned Checks: There is a fee (currently \$36.00) for any checks returned by the bank. This amount may change.

Fee for missed appointments and appointments cancelled without 24 hour notice: A Fee of \$100.00 will be charged to your account for each appointment that was missed or not cancelled at least 24 hours prior to the appointment.

Copies and Transfer of Records: All past due amounts will be collected before medical records are copied or transferred. A nominal fee is assessed to cover copy costs.

Effective Dates: Once you have signed this agreement, you agree to all of the terms and conditions contained herein for this and any future visits, and the agreement will be in full force and effect.

Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency for collections, the undersigned shall pay all collection agency fees and risk being dismissed from the physician care of HVCS.

I have read this Patient Financial Policy, as outlined, and understand that I am ultimately responsible for the charges incurred by me or by my child/children as their legal parent or guardian.

This is an agreement between HVCS as creditor, the Patient, Guardian/Guarantor, or Parent as debtor, named on this form.

In this agreement, the words "you", "your" and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the Heart and Vascular Center of Sarasota, Inc..

By executing this agreement, you are agreeing to pay for all services that are received.

Patient/Guardian Signature

Date

Patient/Guardian Name (PRINTED)

PLEASE NOTE: A signed copy of this agreement will remain in your medical record chart. You may request a signed copy for your records.



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The Heart and Vascular Center Appointment Scheduling and Cancellation Policy

At the Heart and Vascular Center of Sarasota, Inc. we strive to provide excellent care to all of our patients and to schedule appointments so as to accommodate the needs and preferences of our patients.

We typically schedule routine appointments for Office Visits or Testing that the Doctor or ARNPs have ordered at checkout or we will put you in our reminder system and call you several weeks before the appointment is due to schedule.

We ask that you always promptly enter your appointments on your calendar.

We sometimes have to change your appointments due to a provider or technician being unavailable or due to a technical problem. In those cases we will always give you as much notice as possible.

If you have to cancel or reschedule an appointment with us, we ask that you **contact us as soon as you can, or a minimum of 24 hours in advance**, so we may try to fill your spot with someone from the wait list. Dr. Bredlau and the Nurse Practitioners are booked out for months in advance, and we need to be able to use cancellation spots to fill urgent needs. Missed appointments place a significant financial burden on our office.

Not notifying us at least 24 hours in advance or missing an appointment will now result in a fee of \$100.00 per appointment. If you have multiple appointments scheduled on the same day, you could be charged multiple no-show fees. Payment on these fees is due before the appointment/s can be rescheduled.

Please be sure to give us more than one phone number and / or email address to reach you at, and please notify us immediately of any changes. We typically call confirms on appointments, but not receiving a reminder call does not relieve you of your responsibility to keep track of and show for your appointments.

Thank you for your cooperation!

Acknowledged by: _____

Patient Signature

Date



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Heart & Vascular Center of Sarasota may use and disclose protected health information ("PHI") about me to carry out treatment, payment and healthcare operations ("TPO"). Please refer to Heart & Vascular Center of Sarasota's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Heart & Vascular Center of Sarasota reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Heart & Vascular Center of Sarasota, Privacy Officer at 1217 S. East Ave , Suite 104, Sarasota, FL 34239.

With my consent, Heart & Vascular Center of Sarasota may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Heart & Vascular Center of Sarasota may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Heart & Vascular Center of Sarasota may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Heart & Vascular Center of Sarasota restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Heart & Vascular Center of Sarasota's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Heart & Vascular Center of Sarasota may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Patient Name

Name of Legal Guardian



1217 S. East Ave, Suite 104
Sarasota, FL 34239
Ph: 941-365-0433 *** Fax: 941-954-2064

**ASSIGNMENT OF INSURANCE BENEFITS
MEDICARE AND SUPPLEMENTAL INSURANCE**

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to Heart & Vascular Center of Sarasota on my behalf.

I authorize Heart & Vascular Center of Sarasota to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, Heart & Vascular Center of Sarasota may prescribe testing procedures to be performed here. I understand the Heart & Vascular Center of Sarasota is the owner, and I have been advised that according to Florida Law I am under no obligation to use this facility.

I understand that I am responsible for payment of any non-covered service, deductible, and/or co-payment due.

Signature _____ Date _____

COMMERCIAL INSURANCE

I request that payment of authorized benefits be made on my behalf to Heart & Vascular Center of Sarasota for any services provided by Heart & Vascular Center of Sarasota physicians. I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. I understand that I am responsible for payment of any charges in full, including non-covered services, deductible and/or co-payments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. Heart & Vascular Center of Sarasota will request a pre-authorization from your insurance company on procedures ordered by Heart & Vascular Center of Sarasota. It is your responsibility to ensure that an authorization is on file with Heart & Vascular Center of Sarasota prior to having your procedure performed. When applicable, I understand that I am responsible for payment of all charges in full due to no authorization.

Signature _____ Date _____



**The Heart
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Permission to Release Information to Non-Medical Persons

Emergency Contacts

Please list any family members (including spouse), friends or home health care personnel you authorize to receive information on your medical condition (e.g. test results, hospital status appointment information etc.) or billing information.

I, _____ give the Heart & Vascular Center of Sarasota permission to release medical/billing information to the following people:

Name _____ Relationship _____ Phone _____

I, _____ wish the following person to be contacted in an emergency:

Name _____ Relationship _____ Phone _____

Patient Signature

Date



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Permission for E-Mail Communication

Please be advised that email is not considered a secure or HIPPA compliant way of communicating.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

If you are willing to accept that risk and would like to be able to communicate with the office via email, please fill out and sign the information below.

I hereby authorize **The Heart & Vascular Center of Sarasota** to send e-mail correspondence to me containing the following information:

- | | | |
|--|---------|--------|
| 1. Appointment information | yes () | no () |
| 2. Billing information | yes () | no () |
| 3. Medical information (Test Results etc.) | yes () | no () |

Patient Name and DOB: _____ E-mail Address: _____

Signature of patient or authorized representative: _____ Date: _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the **HEART & VASCULAR CENTER OF SARASOTA** Notice of Privacy Practices with the effective date of September 13th 2013.

Patient Name (please print)

Signature of Patient/Patient Representative

Date

Relationship to Patient

Copy made for Patient: _____ Yes _____ No