

Urinary: Urgency Frequent urination Decreased Stream
 Blood in urine Incontinence None
 Other _____

Blood: Bruising Gingival Bleeding Thin blood None
 Other _____

Bone/Joint: Joint pain Backache Stiffness
 Gout Swelling None
 Other _____

Endocrine: Heat intolerance Cold intolerance Frequent Hunger
 High Blood sugar Sweating Thirst None
 Other _____

Past Medical History

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Valvular Heart Disease |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Gastric Reflux |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heart Rhythm Disorder |

Other: _____

Past Surgical History:

1. _____ Month/Year: _____
2. _____ Month/Year: _____
3. _____ Month/Year: _____
4. _____ Month/Year: _____
5. _____ Month/Year: _____
6. _____ Month/Year: _____
7. _____ Month/Year: _____
8. _____ Month/Year: _____

Please mention any other symptoms or illnesses not previously documented:

Family History:

| | | Relationship | Cause of Death? |
|-------------------------|-----|---------------------|------------------------|
| High Blood Pressure | [] | _____ | _____ |
| Heart Murmur | [] | _____ | _____ |
| Coronary Artery Disease | [] | _____ | _____ |
| Emphysema | [] | _____ | _____ |
| Asthma | [] | _____ | _____ |
| Heart Attack | [] | _____ | _____ |
| Kidney Disease | [] | _____ | _____ |
| Liver Disease | [] | _____ | _____ |
| Diabetes | [] | _____ | _____ |
| Seizures | [] | _____ | _____ |
| Cancer | [] | _____ | _____ |
| Stroke | [] | _____ | _____ |
| Thyroid Disease | [] | _____ | _____ |
| Other: | | _____ | _____ |

Social History:

Who lives with you now?

Who would be available to help you in the event of a major operation?

Employment (circle): Employed Student Disabled Retired Unemployed

Previous/Current employment: _____

Marital Status: Single Married Divorced Separated Widowed

Smoking history (circle): Never Smoked

Smoke now - How Often? _____

Previous Smoker - Quit smoking (date) _____/_____

Alcohol history (circle): Never Drink

Drink now - How Often? _____

Previous Drinker - Quit drinking (date) _____/_____

Cardiac Procedures:

| | Date | Hospital/Clinic |
|-------------------------------|-------------|------------------------|
| Echocardiogram: | | |
| Chest CT Scan/MRI: | | |
| Heart Catheterization: | | |
| Other: | | |
| | | |

Florida Advanced Cardiothoracic Surgery

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I _____ have received a copy of this office's
Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- Other (Please Specify)

Notice of Privacy Practices

This is a Notice of Privacy Practices for:
Florida Advanced Cardiothoracic Surgery, LLC

Purpose: This Notice of Privacy Practices (“**Notice**”) presents the information that federal law requires us to give our patients regarding our privacy practices.

Florida Advanced Cardiothoracic Surgery, LLC is required to provide you with this Notice pursuant to the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”) (“**Privacy Rules**”). We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice and on our website. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

OUR OBLIGATIONS

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal obligations, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2006, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you when you first receive services from us after the date the revised Notice becomes effective or upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for our treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use or disclose your health information to your health insurer to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. For example, we may use or disclose your health information in order to conduct an internal assessment of the quality of care we provide.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, to the extent necessary to help with your health care or with payment of your health care, if you agree that we may do so. We may also advise these persons of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is

directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disclosures Permitted or Required by Law: We are permitted and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

1. To public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse and other public health issues;
2. to health oversight agencies such a governmental auditors, the Florida Agency for Health Care Administration, the Florida Department of Health and other agencies when required;
3. to any individual when Florida Advanced Cardiothoracic Institute, P.L. is ordered by a court or other legal process to do so;
4. To law enforcement officials when necessary for law enforcement purposes and required by law;
5. to a coroner or medical examiner when necessary to enable them to perform their duties;
6. to organ procurement organizations, to enable them to make suitability determination;
7. In cases of emergency; or
8. To researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as a voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Your Authorization: Other uses and disclosures of your health information will be made if you give us written authorization to do so. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

PATIENT RIGHTS

You have certain rights regarding your health information. These rights include:

1. The right to obtain a paper copy of this Notice;
2. The right to inspect and copy your health information (copies are available for a reasonable fee);
3. The right to request amendments to your health information you believe to be inaccurate;
4. The right to obtain an accounting of Florida Advanced Cardiothoracic Surgery uses and disclosures of your health information, subject to certain exceptions;
5. The right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request); and
6. The right to request that communications regarding your health information be sent by alternative means or at alternative locations.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or wish to exercise any of your rights described herein, please contact using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Danielle McKinnon

Telephone: 813-844-3228

Facsimile: 813-844-7730