

Simie B. Platt, M.D., F.A.C.C.

Practice Limited to Cardiac Electrophysiology

3370 Burns Road, Suite 105 , Palm Beach Gardens, FL 33410

Phone: 561.630.8570/Fax: 561.630.8572

Mr. / Mrs. _____

APPT DATE: _____ TIME: _____

Please remember to bring the following:

- **Please bring all medications you are taking in a bag**
- **Insurance and ID card**
- **Insurance referral if applicable**
- **Co pays are due at the time of visit**
- **There is a \$25.00 charge for no shows**
- **Cancellations should be done 24 hrs. prior to appointment**

DIRECTIONS TO OFFICE

GOING SOUTH

Take I-95 **South** to the exit marked "Military Trail South" (1 exit AFTER the exit for Donald Ross Road). Once you are Military Trail going south, go to the 3rd light (2nd light will be PGA Boulevard) at Burns Road. Turn left onto Burns Road. Continue approximately 1.5 miles (go over railroad tracks and cross Alt. A1A) and you will see Palm Beach Gardens Medical Center on your right. We are the building connected to the hospital (see address above).

GOING NORTH

Take I-95 North to the exit marked "Northlake Boulevard." Turn left onto Northlake Boulevard, going west to Military Trail. Turn right (north) onto **Military Trail** (you may also take Military Trail from any southern point as well) to Burns Road. Turn right (east) onto Burns Road. Continue approximately 1.5 miles (go over railroad tracks and cross Alt. A1A) and you will see Palm Beach Gardens Medical Center on your right. We are the building connected to the hospital (see address above).

Simie B. Platt M.D., F.A.C.C.
NEW PATIENT INFORMATION SHEET

NAME _____ LANGUAGE _____

LOCAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # () _____ CELL # () _____ EMAIL _____ @ _____

RACE _____ ETHNICITY _____ NATIONALITY _____

PHARMACY _____ LAB _____

SS # _____ - _____ - _____ DATE OF BIRTH _____ / _____ / _____

*** We request the name of one person allowed to act on your behalf in the event we need to make a change in your medication, discuss any test results, or reschedule an appointment in your absence ***

CONTACT _____ PHONE # () _____

RELATIONSHIP _____ CELLULAR # () _____

MEDICAL INSURANCE _____ 2nd INS. _____

REFERRING M.D. _____ PHONE: () _____
FAX: () _____

PRIMARY M.D. _____ PHONE: () _____
FAX: () _____

ASSIGNMENT RELEASE: I hereby authorize the above named carriers, authorized agents, and clients thereof, to release any pertinent information required for settlement of services provided by Simie B. Platt, M.D. and/or Matthew H. Klein, M.D. with payment going directly to same. I further acknowledge and accept financial responsibility for any services, deductibles, co-pays, and other miscellaneous fees not covered by my insurance company.

ACKNOWLEDGEMENT OF PRIVACY ACT INFORMATION: I have reviewed my copy of the Notice of Privacy Practices provided by Simie B. Platt, M.D., and I do understand my rights.

CONSENT TO TREATMENT: I agree for a health professional to provide care.

Patient's Signature

Date

HIPAA Notice of Privacy Practices

I

Electrophysiology Consultants, Inc.

Simie B. Platt, M.D.

3370 Burns Road, Suite 100, Palm Beach Gardens, FL 33410 – (561) 630-8570

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have reviewed this Notice of our Privacy Practices. A separate brochure outlining these rights is available to you, upon your request to the Office Manager.

Print Name _____ Signature _____ Date _____

Simie B. Platt, M.D., F.A.C.C.

DOS: ___ / ___ / ___

Patients Name: _____

DOB: ___ / ___ / ___

REFERRING: _____

PCP: _____

DO YOU HAVE A HISTORY OF?

High blood pressure _____
Diabetes _____
High Cholesterol _____
Prostate enlargement _____
Other _____

Thyroid _____
Stroke/TIA _____
Syncope _____
Asthma _____
REVIEWED BY: _____

Bypass surgery _____
Heart valve surgery _____
Pacemaker _____
Defibrillator _____
Angioplasty/stents _____
Other _____

Cholecystectomy _____
Hysterectomy _____
Hernia Repair _____
Tonsillectomy _____
Mastectomy _____
REVIEWED BY: _____

SOCIAL HISTORY – Check the appropriate boxes and fill in the accurate amounts of standard portions.

Employed _____ Retired _____ Occupation _____
Single _____ Divorced _____ Married _____ Widowed _____
Number of Children _____ Ages: _____ Religious affiliation: _____

Mental Activity: (Reading / Paying Bills / Political Discussion Group / Work) _ Light _ Moderate _ Heavy Physical
Activity: (Exercise / Sports / Gardening, etc.) _ Light _ Moderate _ Heavy Hours Per Day: _____
Alcohol: _ Never _ Beer(s) ___ Per Week _ Liquor ___ Per Week _ Wine ___ Per Week How Many Years? _
Smoking: _ Never _ Current _ Previous _ Discontinued Quantity: _____ How Many Years?: _____
Nutritional Information: _ Low Sodium _ Diabetic Diet _ Low Fat Diet _ Vegetarian Diet _ Low Cholesterol _ Other
Miscellaneous Drugs: _ Antacids _ Diet Pills _ Laxatives _ NutraSweet _ Decongestants _ OTC histamines _
Other _____

Are you allergic to iodine contrast? _____

Do you have any objection to receiving blood transfusion or blood products? _____

REVIEWED BY: _____

Family History (Check all that apply):

Parents: Mother: age: _____ Died at: _____
Father: age: _____ Died at: _____

Do your immediate family members have a history of?

Heart Attack _____ Bypass Surgery or Angioplasty _____
Sudden Death _____ Arial fibrillation _____ High Blood Pressure _____
Diabetes _____ Congestive Heart Failure _____ Cancer (type): _____

REVIEWED BY: _____

Simie B. Platt, M.D., F.A.C.C.

DOS: ___ / ___ / ___
Patients Name: _____
DOB: ___ / ___ / ___
REFERRING: _____
PCP: _____

REVIEW OF SYMPTOMS – Circle only the ones you NOW have or have had recently

Allergies: _____ NONE _____

General: Weaknesses _ Fatigue _ Fever _ Chills _ Night Sweats _ Fainting _ _____ NONE _____

Skin: _ Color changes in moles _ Size changes in moles _ Red Dots/Spots _ _____ NONE _____

Head: _ Headaches _ Head injuries _ _____ NONE _____

Eyes: _ Transient loss of vision _ Glaucoma _ _____ NONE _____

Ears: _ Recent loss of hearing _ Dizziness _ Loss of balance _ _____ NONE _____

Nose: _ Nasal discharge _ Post nasal drip _ _____ NONE _____

Mouth: _ Dental problems _ Oral sores _ _____ NONE _____

Throat: _ Difficulty swallowing _ Hoarseness, present for more than two weeks _ _____ NONE _____

Neck: _ Neck enlargement _ Neck lumps _ Neck masses _ _____ NONE _____

Lungs: _ Cough _ Phlegm _ Coughing blood _ Shortness of breath _ Wheezing _ Pain in lungs _ _____ NONE _____

Blood: _ Anemia _ Easy bruising _ Prolonged bleeding _ Swollen nodes _ Painful nodes _ _____ NONE _____

Gastrointestinal: _ Change in bowel habits _ Abdominal pain _ Nausea _ Vomiting _
Abdominal bloating _ Belching _ Heartburn _ Indigestion _ Irregular bowels _ Constipation _
Diarrhea _ Gas _ Hemorrhoids _ Hernias _ Poor appetite _ Food intolerance _ Bloody stools _
Black tarry stools _ Rectal bleeding _____ NONE _____

Genitourinary: _ Urinary frequency _ Frequent urination _ Urinary stones _ Urinary burning _
Bloody urine _ Urethral discharge _ Urination at night _ _____ NONE _____

Gynecological: _ Post-menopausal bleeding _ Hot flashes _ Mood swings _ Night sweats _ _____ NONE _____

Musculoskeletal: _ Muscular pain _ Muscle weakness _ Joint stiffness _ Joint pain _
Joint swelling _ Joint deformities Curvature of spine _ _____ NONE _____

Neurological: _ Seizures _ Vertigo _ Hand trembling _ Loss of sensation _ Incoordination _
Transient paralysis of upper or lower extremities _ Slurred speech _
Tingling / burning / numbness _ Loss of memory _ Disorientation _ Gait shuffling _ _____ NONE _____

Psychiatric: _ Insomnia _ Irritability _ Anxiousness/ stress _ Panic attacks _____ NONE _____

REVIEWED BY: _____

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DOS: ___ / ___ / ___
Patients Name: _____
DOB: ___ / ___ / ___
REFERRING: _____
PCP: _____

CHIEF COMPLAINT & PRESENT ILLNESS: **DO NOT COMPLETE**

ARRHYTHMIA MONITOR: _____

EST: _____

ECHO: _____

CATH: _____

Physical Exam: _____ BP = _____ HR = _____ R = _____

SKIN: WNL - warm, dry, no lesions or rashes abnormal _____
EYES: WNL - anicteric, non-injected, conj pink abnormal _____
MOUTH: WNL - oral mucosa abnormal _____
LUNGS: WNL - lungs clear bilaterally abnormal _____
NECK: WNL - supple, trach midline, no JVD or bruits, carotid upstrokes normal abnormal
CV: WNL - regular irregular
ABD: WNL - soft, non tender
EXT: WNL - no edema Pulses
NEURO: WNL - grossly intact

Assessment and Plan:

The risks, alternatives and benefits were discussed with the patient. _____

MD Signature

