

NEW PATIENT INTAKE

Patient Information

Full Legal Name

Date of Birth (MM/DD/YYYY)

Social Security Number (if applicable)

Phone Number

E-mail Address

Primary Care Physician

Phone Number

Preferred Pharmacy

Crossroads of Pharmacy

HIPAA Acknowledgement

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for Flow Heart & Vascular. This notice explains how my protected health information may be used and disclosed for purposes of treatment, payment, and healthcare operations, as well as other uses permitted or required by law. I understand that I may review the Notice of Privacy Practices and request a copy at any time. I understand that I may request restrictions on certain uses or disclosures of my information, though the practice is not required to agree to all requested restrictions. Information disclosed as permitted by law may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Patient/Representative Signature

Date (MM/DD/YY)

Consent for Treatment

I consent to receive medical evaluation and treatment from Flow Heart & Vascular and its physicians, providers, and staff. This may include examinations, diagnostic testing, and other services necessary for my care. I understand that the practice of medicine is not an exact science and that no guarantees have been made regarding the results of my treatment. I understand that I may ask questions about my care at any time. I may refuse or withdraw consent for treatment at any time.

Patient/Representative Signature

Date (MM/DD/YY)

MEDICAL HISTORY

Recent Hospital Visits in the Past 6 Months (Select all that Apply)

- ☐ Visited the Emergency Room
- ☐ Been Admitted to the Hospital
- ☐ Undergone Surgery
- ☐ None of the Above

If applicable, please briefly write the details of the hospital visit below.

Please list any medications you are currently taking, please include dosage and frequency.

Please briefly share any relevant medical history.

Please provide any other information or details that you would like us to be aware of.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Full Legal Name

Date of Birth (MM/DD/YYYY)

I authorize Flow Heart & Vascular, LLC and its physicians, staff, and affiliated providers to disclose my protected health information (PHI) to the individuals listed below. This authorization allows these individuals to receive information regarding my medical care, including but not limited to:

- Medical conditions and diagnoses
- Test results (labs, imaging, cardiac testing, etc.)
- Treatment plans and medications
- Appointment scheduling and care coordination
- Billing or insurance matters related to my care

By signing this form, I understand that I may revoke this authorization in writing at any time by contacting the provider above. Revocation will not apply to information already released based on this authorization. Your treatment, payment, enrollment, or eligibility for benefits will not be affected. Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Authorized Individuals: (Friends, Family, Etc.)

Name

Phone Number

Relationship

Name

Phone Number

Relationship

Name

Phone Number

Relationship

Patient/Representative Signature

Date (MM/DD/YY)

MEDICAL RECORDS RELEASE FORM

Patient Information:

Full Name

Date of Birth (MM/DD/YYYY)

Phone Number

Request Information From:

Release Information From (Name of Facility or Provider)

Address

Phone

Fax

Information to Be Released

☐ Complete Medical Record

☐ Continuation of Care

Authorization Expiration

This authorization will expire one year from the date of signature. You may revoke this authorization in writing at any time by contacting the provider above. Revocation will not apply to information already released based on this authorization. Your treatment, payment, enrollment, or eligibility for benefits will not be affected. Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Patient/Representative Signature

Date (MM/DD/YY)