THIS IS THE NEW PATIENT PACKET FOR:

DR HOWARD TEE

960 37TH PL. STE 105

VERO BEACH, FL. 32960

772-299-1901

PLEASE COMPLETE FRONT AND BACK PAGES AND RETURN TO OUR OFFICE AT LEAST 2 WEEK PRIOR TO YOUR APPT ON

IF THE PAPERWORK IS

NOT RETURNED AS REQUESTED, WE WILL RESCHEDULE THE APPT.

Welcome to the Cardiology practice of Howard Tee, MD, FACC. The staff and nurses in this practice will provide the utmost concern and compassion to our patients as well as being professional at all times. We expect that our patients treat the staff with the same professionalism.

The following will be the new policies effective immediately:

----- This office is a Cardiology practice with assigned appointments made by the front desk. If there is an emergency, please be mindful that the ER would be the best place for you or by calling 911. There is a triage line when calling our office, where you may leave a message, and our nurses will get back to you after discussing the matter with the Dr. This will be based on the urgency of the matter and will be treated as a visit.

----- Effective 01/01/24, any patient who does not show up for their scheduled appointment 3 times, will be discharged from the practice.

----- Due to the overwhelming number of patients, all New patients who do not show up for their scheduled appointments, will be discharged and unable to reschedule.

----- This is an extremely busy practice and there will be times that you will have to be seen by a Nurse Practitioner. Every patients' case will be discussed with the provider, and if needed, will be seen by the provider during special circumstances. The provider may have emergencies in the hospital and will have the Nurse Practitioner see the patients to take care of your needs. Refusing to see the Nurse Practitioner initially is not an option.

----- The practice of taking care of patients is a two way street. Please be respectful to the staff and raising your voice, being rude, or using foul language will not be tolerated.

Please sign that you have read and understand:____________________________

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.
Patient Registration

Date:______________________________

Name: ____________________________ DOB: __________________ Sex: ☐Male ☐Female

Address: ____

City: __________________________ State: __________________________ Zip: ____________________

Phone:
Home __________________________ Work: __________________________ Cell: ____________________

Email: ________________________________ Race: __________ Social Security: ____________________

Marital Status: Married Widowed Single Divorced Spouce's Name: ____________________

Language:
☐ English ☐ Spanish ☐ French ☐ Other

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Emergency Contact: ______________________________ Phone: ________________________________

Primary Insurance:__ ____

(Circle One): PPO POS HMO Indemnity

ID Number:______________________________ Group Number: ________________________________

Insured's Name:__________________________ Insured's Date of Birth: ____________________________

Insured's Relationship: ____

Secondary Insurance: ____

ID Number: ______________________________ Group Number: ________________________________

Insured's Name: __________________________ Insured's Date of Birth: ____________________________

Insured's Relationship: ____

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

Authorization to Use or Disclose My health Information

Patient Name: ______________________ Date of Birth: ______________________

I. **My Authorization**

You may use or disclose the following health care information (circle yes or no):

All my health information maintained by Dr. Tee	YES	NO
My health information related to drug abuse	YES	NO
My health information related to alcohol abuse	YES	NO
My health information related to HIV/AIDS	YES	NO
My health information related to psychological or psychiatric conditions	YES	NO

My health information relating to the following treatment or condition ______________________

My health information for the date(s) ______________________

Other: ______________________

You may disclose this information to:

Name or Organization: ______________________

Address: ______________________

Check all that apply:

My Spouse	Name: ______________________	Phone: __________
My Son/Daughter	Name(s): ______________________	Phone: __________
My Mother/Father	Name(s): ______________________	Phone: __________
My Friend	Name(s): ______________________	Phone: __________
My Lawyer	Name(s): ______________________	Phone: __________
My Caretaker or Living	Facility: ______________________	Phone: __________
My Power of Attorney	Name: ______________________	Phone: __________
Other	Specify: ______________________	Phone: __________

This Authorization Ends On: Date: __________ When the following event occurs: __________

II. **My Rights**

I understand that I do not have to sign this authorization in order to get health care benefits 9 treatment, payment or enrollment). However, I do have to sign an authorization form to take part in research study or to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke authorization if its purpose was to obtain insurance. Two ways to revoke authorization are: Fill out a revocation form, which is available from the office or write a letter to the office. Once the office discloses health information, the person or organization that receives it may re- disclose it. Privacy laws may no longer protect it.

______________________ __________ __________

Patient or legally authorized individual signature | Date | Time

______________________ ______________________

Printed name if signed on behalf of patient | Relationship to Patient

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

Name: ____________________ DOB: ____________________ Age: ________

Referring M.D.: ____________________ Primary M.D.: ____________________

Preferred Pharmacy: ____________________ Pharmacy Phone: ____________________

Have you ever been treated for or do you have any complaints of:

Yes [ ] No [ ] Chest Discomfort
Yes [ ] No [ ] Shortness of breath when walking or lying down
Yes [ ] No [ ] Irregular heatbeats or palpitations
Yes [ ] No [ ] Calf cramps when walking
Yes [ ] No [ ] Heart Failure
Yes [ ] No [ ] Heart murmur or heart valve problem
Yes [ ] No [ ] Heart valve replacement If yes, give date(s)____________________
Yes [ ] No [ ] Heart attack If yes, give date(s) ____________________
Yes [ ] No [ ] Blacking out or passing out
Yes [ ] No [ ] Stroke If yes, give date(s) ____________________
Yes [ ] No [ ] Rheumatic Heart Disease
Yes [ ] No [ ] Coronary Artery Bypass Grafting (open Heart surgery) If yes, give date(s): ____________
Yes [ ] No [ ] Coronary angioplasty (PTCA or balloon technique, stents) If yes, give date(s) ____________

Yes [ ] No [ ] Have you ever been told you have diabetes or "high blood sugar"?
If yes, how long have you had diabetes?: ____________________
How is your diabetes treated?: (Circle one) pills insulin

Yes [ ] No [ ] Have you ever been told you have high blood pressure?
If yes, how long have you had high blood pressure?: ____________________
How long have you received medication for your high blood pressure?: ____________________

Yes [ ] No [ ] Have you ever been told you have high cholesterol or triglycerides (blood fats)?
What was your last cholesterol level? ____________________
What were your last triglycerides?: ____________________
When was the above cholesterol/triglyceride level done?: ____________________

Women Only:

Yes [ ] No [ ] Are you postmenopausal?
Yes [ ] No [ ] Have you had a hysterectomy?
If yes, give date: ____________________

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

/ many siblings do you have?
isters ______________________________
rothers ______________________________

se answer the following:

Relationship	Sex: Male (M) Female (F)	Living (1) Deceased (2)	If deceased, age at death	Heart Attack	Heart Surgery	High Blood Pressure	High Cholesterol	Stroke
Father								
Mother								
Sibling #1								
Sibling #2								
Sibling #3								
Sibling #4								
Sibling #5								
Sibling #6								

Marital Status: [ ] Married, number of years ______________ [ ] single [ ] Divorced [ ] Widow
Live with: [ ] Spouse [ ] Children [ ] Alone [ ] Friend [ ] Relative [ ] Other ______________

Employment Status:
[ ] Employed [ ] Unemployed [ ] Retired [ ] Homemaker [ ] Other ______________

Yes [ ] No [ ] Do you drink alcohol or beer?
If yes, how many drinks per: Day __________ Week __________ Year __________

Yes [ ] No [ ] Do you drink coffee, tea, or soda with caffeine?
If yes, how many cups per day? ______________

Yes [ ] No [ ] Have you ever smoked cigarettes?
What age did you start smoking?: ______________
How many years did you smoke?: ______________
How many packs per day did you smoke?: ______________
When did you stop smoking?: ______________

How many children do you have?: ______________
Do any of your children have heart disease? [ ] yes [ ] No

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

Name: ______________________ DOB: ______________ Patient's Age: __________

PMH Describe on the lines below any problems you have had with the following:

ROS
Brain or Neurological Problem(s) ______________________
Thyroid Disease ______________________
Carotid Artery Disease ______________________
Lung/Breathing ______________________
Stomach/Ulcers/Intestines ______________________
Blood/Bleeding Problems ______________________
Liver ______________________
Kidney ______________________
Bladder ______________________
Prostate ______________________
Peripheral Vascular Disase(Leg blood vessels) ______________________
Leg Cramps ______________________
Cancer ______________________
Glaucoma ______________________
Arthritis/Gout ______________________

OP Please list all operations you have had and dates of surgery

____
____
____
____
____

Yes [ ] No [ ] Have you ever had a vein stripping of your legs?

Yes [ ] No [ ] Are you allergic to contrast or IVP dyes used in medical tests?
Yes [ ] No [ ] Are you allergic to shell fish?
Yes [ ] No [ ] Are you allergic to any medications?
If yes, describe the reactions you had below.

AL

Medication	Reaction Type

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

IED Please list all medications you are taking. Include the dosage and directions.

Medication	Dosage	How often

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

3. **NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during Hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician or Independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

I hereby consent to engaging in virtual health/telemedicine services, where available, as part of my treatment. I understand that "virtual health" or telemedicine services includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications.

5. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

Please check one:

☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).

Patient Label

- ☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.
- ☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

6. **RESEARCH STUDIES:**

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* ______________________________

Who can the Physician Clinic contact with questions about the Study? ______________________.

7. **CONSENT TO PHOTO/VIDEO:**

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9. **E-MAIL:**

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

10. **CELL PHONES:**

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11. **VIDEOTAPING/RECORDING:**

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, If Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Physician Practice Authorization Form – Consent to Medical Treatment

Patient Label

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

Your Privacy is very important to us. In order for us to speak with anyone other that yourself, we must have your permission.

If you give permission for us to communicate with anyone other than yourself, please complete the list below:

Name/Phone Number	Relationship	Options
1		☐Billing Information ☐Appointment Information ☐Medical/Health Information
2		☐Billing Information ☐Appointment Information ☐Medical/Health Information
3		☐Billing Information ☐Appointment Information ☐Medical/Health Information
4		☐Billing Information ☐Appointment Information ☐Medical/Health Information
5		☐Billing Information ☐Appointment Information ☐Medical/Health Information

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (Print)

Relationship to patient

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

960 37TH Place, Ste 105 ○ Vero Beach, FL 32960 ○ Phone: (772)299-1901 ○ Fax: (772)299-1904

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ______________________________
SSN: ______________________________
DOB: ______________________________
Phone: (   )______________________________

I hereby authorize: (To get records from)

Facility Name: ______________________________

Facility Address: ______________________________
____
____

I hereby authorize: (To release records to)

Facility Name: Howard Tee, M.D.

Facility Address: 960 37th Place, Suite 105
Vero Beach, FL 32960
Phone: 772-299-1901
Fax: 772-299-1904

To release any or all: (Please be specific on records requesting) this release is to include any and all HIPAA protected medical records.

____
____
____

I understand and direct that this authorization is to remain in effect indefinitely or until I revoke it in writing.

______________________________ Patient Signature

______________ Date