Kenneth H. Zelnick, M.D., F.A.C.C.
Clinical and Interventional Cardiology
Board Certified

4101 N.W. 4th St. #104
Plantation, Florida 33317
Phone: (954) 681-4088
Fax: (954) 678-0166

NEW PATIENT INFORMATION

DATE: ________________

LAST NAME: ______________________________ FIRST NAME: __________________________

DATE OF BIRTH: ________________ AGE: ________ SEX: M/F______ SS#__________________

ADDRESS: ____

CITY: ______________________________ STATE: ___________ ZIP CODE: __________________

HOME PHONE #: ____________________________ CELL PHONE #: _______________________

EMAIL ADDRESS: ____

EMERGENCY CONTACT: __________________________ PHONE #: _______________________

PRIMARY PHYSICIAN: __________________________ PHONE #: _______________________

REFERRING PHYSICIAN: ________________________ PHONE #: _______________________

PHARMACY NAME: ____

PHONE #: ____________________________ CITY: __________________ ZIP CODE: __________

RACE
SELECT ONE:
- AMERICAN INDIAN OR ALASKA NATIVE
- ASIAN
- NATIVE HAWAIIAN OR OTHER PACIFIC
- BLACK OR AFRICAN AMERICAN
- WHITE
- HISPANIC
- OTHER RACE
- OTHER PACIFIC ISLANDER
- UNREPORTED/REFUSED TO REPORT

ETHNICITY:
SELECT ONE:
- HISPANIC OR LATINO
- NOT HISPANIC
- REFUSED TO REPORT

LANGUAGE: SELECT ONE:
- ENGLISH
- SPANISH
- CREOLE
- FRENCH
- RUSSIAN
- OTHER

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Nuclear Stress Test Cancellation Policy

Dear Patient:

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Nuclear Stress Test Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We request that you please give our office a **minimum ~~48~~ 24 hour business day** notice in the event that you need to reschedule your stress test. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, or cancels within the 48-hour window this is considered a missed appointment ("No-Show, No-Call.") and a **fee of $200.00 will be charged** to you for a missed appointment as the medication has already been ordered for you by that time.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Nuclear Stress Test Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, ______________________________ (print name), have received a copy of Dr. Kenneth H. Zelnick's Nuclear Stress Test Cancellation Policy.

____
Printed Name of the Patient Relationship to Patient (if patient is a minor)

____
Signature of Patient or Responsible Party if a Minor

____
Date

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AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize KENNETH H. ZELNICK, M.D., P.A. to obtain any and all medical records concerning my care for any physician, hospital, or other health care professional that has provided medical care to me in the past.

I also authorize KENNETH H. ZELNICK, M.D., P.A. to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize KENNETH H. ZELNICK, M.D., P.A. to release any and all medical records concerning my care to Medicare, Medical, any insurance company, third party administrator, or managed care company.

______________________________ __________________
Patient Signature Date

______________________________ __________________
Printed Name Date of Birth

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of KENNETH H. ZELNICK, M.D., P.A. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____I do not authorize KENNETH H. ZELNICK, M.D., P.A. to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize KENNETH H. ZELNICK, M.D., P.A. to verbally release any and all information concerning my medical care to the following individuals.

______________________________ __________________
Name Relationship to Patient

______________________________ __________________
Patient Signature Date

_____ I authorize KENNETH H. ZELNICK, M.D., P.A. to leave messages regarding my medical care of appointments on my answering machine.

NOTICE OF PRIVACY PRACTICES (continued)

Our responsibilities:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice. We reserve the right to change the terms of our Notice and you are entitled to receive a revised copy of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

Other disclosures and uses:

NOTIFICATION:
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

COMMUNICATION WITH FAMILY: (Family, Friends, and Caregivers)
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

FOOD AND DRUG ADMINISTRATION (FDA):
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

WORKERS' COMPENSATION:
If you are seeking compensation through Workers' Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers' Compensation.

PUBLIC HEALTH:
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

ABUSE & NEGLECT:
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

CORRECTIONAL INSTITUTIONS:
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

LAW ENFORCEMENT:
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

HEALTH OVERSIGHT:
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS:
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

OTHER USES:
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by Federal, State, or Local law or with your written authorization and you may revoke the authorization as previously provided.

WEBSITE:
If we maintain a website that provides information about our entity, this Notice will be on the website.

CHECK ONE

☐ **I request the following restrictions to the use or disclosure of my healthcare information:**

____

____

____

I have received a copy of this practice's Notice of Privacy Practices:

PRINT NAME ______________________________

SIGNATURE ______________________________ DATE ______________