Dr. Tong Liu M.D Ph.D. FACC

CENTRAL FLORIDA
HEART CENTER

We are excited to welcome you to the practice of Dr Tong Liu MD. Ph.D. Dr. Tong Liu has been in practice with Central Florida Heart Center since August of 2012. We have two locations, one in Ocala and one in Inverness. She has an extensive medical background in Non-Invasive cardiac care including her PHD in Atrial Fibrillation.

For your upcoming appointment on _____ @_____am/pm. Please remember to arrive 15 minutes early, bring your ID and Insurance cards, a list of all medications with dosage and how many times you take a day. Please fill out our new patient paper work that is attached to your visit, also please bring any recent cardiac records/ testing results if applicable.

We look forward to providing you with all your cardiac needs!

3310 SW 34TH ST OCALA, FL 34474
330 S. LINE AVE INVERNESS, FL 34452

352-873-4733 PHONE
352-873-2406 FAX

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Patient Demographics

Name:	**Today's Date:**
Address:	**DOB:**
Home Phone:	**Age:**
Cell Phone:	**Email address:**
Primary Care Provider:	**Gender:**
Marital Status: Circle one Single Married Divorced Widow	**SSN:**
Current or former occupation:	**Retired?** Yes / No
Race: (circle) White Black American Hispanic/Latino Asian Native American American Indian Other:	**Preferred Language: (circle)** English Spanish Mandarin/Cantonese

Emergency Contact Information:

Name:	Relationship to patient:	Phone Number:

Insurance assignments and authorization to release information:

I do hereby authorize any physician examining and/or treating me to release to any third payer (such as insurance company or government agency) and medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in the connecting with determining a claim for payment for such treatment and/or diagnosis. I do hereby authorize payment directly to any physician examining or treating me for medical benefits otherwise payable to me for their services, but do not exceed there reasonable and customary charge for these services. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me. I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the physician's office. I agree that should the amount of the insurance benefits be insufficient to be cover the expense that I will be responsible for payment for the difference. I will be responsible for the entire amount due for professional services rendered in the expense is not \covered by my policy or if uninsured.

Patient Signature (Guardian)	Today's Date:

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Patient Name: _____

Medical History	Yes	No	Current?
Coronary Artery disease			
Chest Pain			
Shortness of breath			
Carotid Artery Disease			
Hyperlipidemia			
High Blood pressure			
Heart Failure			
Stroke/ TIA			
Heart Valve disorder			
Atrial Fibrillation			
Palpitations			
Diabetes			
Loss of consciousness			

Other cardiac medical conditions not listed? Yes / No. If yes please list below:_____

Social History:

Current Smoker:☐ Former Smoker:☐ Non- Smoker: ☐
If current smoker how many per day: _____ If current smoker for how long: _____
If former smoker, when did you quit: _____
Alcohol: ☐ Drinks per week: _____ Type of Alcohol: _____
Caffeinated Beverages: ☐ How many cups per day: _____
Recreational Drug use: ☐ If yes which drugs: _____
Family History:
Mother: Living_____ Deceased_____ Father: Living_____ Deceased_____
Please list any cardiac related issues for immediate family and which member had the diagnosis:
_____

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Medication List

Patient Name:	DOB:
Medication Allergies:	Reaction:

Medication	Dosage	Frequency

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Notice of Privacy practices and Authorization form

Today's Date: _____

I acknowledge that I have received a copy of Central Florida Heart center's notice of privacy practices

In the event that a copy of my personal health information is needed for reasons other than the immediate treatment, I hereby authorize the following family members or friends, to act on my behalf, the release of personal health information to them.

Name:_____ Relationship:_____Contact Phone Number:_____

Name:_____ Relationship:_____Contact Phone Number:_____

Name:_____ Relationship:_____Contact Phone Number:_____

Name:_____ Relationship:_____Contact Phone Number:_____

I understand that I may amend this authorization at any time.

I also understand that any other requests for personal health information by anyone else other than those listed above will require additional authorization by myself in writing.

Patient Signature: _____

Witness: _____

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Authorization for Release of Medical Information

By signing this form, I authorize you to release confidential health information about me. By releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility listed below.

Patient's Name: _____ DOB: _____

Phone Number: _____ SSN: _____

The information you may release subject to this signed release form is as follows:

____Complete Records ____ History & Physical ____Progress Notes ____Discharge Summary
____Lab Results ____All Cardiac Testing Reports ____Other (please is below)

_____

_____

_____

Please release my protected health information to the following Physician/Person/Facility below:

Name/Facility: Dr. Tong Liu Central Florida Heart Center
Address: 3310 SW 34th St Ocala, Fl 34474
Phone: 352-873-4733 options 1
Fax: 352-873-2406
Patient Signature: _____
Witness: _____ Todays Date: _____

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No-Show / Cancellation Policy

What if I miss my appointment to see the physician/provider or for diagnostic testing?

While we understand that on rare occasions issues may arise, causing you to miss your appointment,"no-show" and last minute cancellations create problems for both patients and providers. When patients do not show up for their scheduled appointments it fills an appointment block that another patient could use and creates longer than necessary wait times for patients who need to be seen promptly.

In order to provide timely and efficient care to our patients, scheduled appointments must be cancelled or rescheduled at least 24 hours in advance of the appointment time. If we are not notified at least 24 hours in advance of the appointment, then you will be considered a "no-show". Our office will charge a "no-show" fee of $50.00 for office visits and $75.00 for Diagnostic Testing if the appointment is not cancelled within the appropriate time.

Cancelled appointments are the patient's responsibility to reschedule.

I have read, understand, and agree to the above No-Show/Cancellation Policy.

_____ _____

Patient or Authorized Representative Signature **Date**

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Financial Policy

Thank you for choosing Dr. Tong Liu as your health care provider. We are committed to building a successful physician-patient relationship and providing you with excellent medical care. Your understanding of our financial policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions:

When is payment due?

All copayments, deductibles, patient responsibility amounts and past-due balance are due at the time of check-in unless prior arrangements have been made with the physician and billing office.

How may I pay?

We accept payment by cash, check, and most major credit cards.

Will you bill my insurance?

We will bill your primary insurance company on your behalf. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information. It is your responsibility to notify our office promptly of any information changes. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance.

Do you charge a penalty for returned payments?

Yes. Returned checks and credit care chargebacks will be accessed a minimum $10.00 fee in addition to the balance owed.

I have read, understand, and agree to the above Financial Policy.

_____ _____

Patient or Authorized Representative Signature **Date**

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