Awais K. Humayun, MD, FACC, FHRS

Authorization for Disclosure of Protected Health Information

This *Authorization for Disclosure of Protected Health Information* (PHI) form should be signed after you receive a copy of Heart Rhythm Solutions' *Notice of Privacy Practices*. **Your signature authorizes Heart Rhythm Solutions (HRS), the office of Awais K. Humayun, to receive, use, and disclose protected health information (PHI) about you as described in the aforementioned notice.**

I understand that services provided by Heart Rhythm Solutions (HRS) are reliant upon receipt of PHI to provide treatment, claim payments, bill services, manage health care operations, contact me, and if specified, communicate with my family, or others identified in this authorization. I understand that there are other, less common, potential uses and disclosures of PHI, which have been explained in *Part II of HRS' Notice of Privacy Practices*. I understand my rights to revocation of this authorization, as well as my rights with respect to PHI as they were explained in *Part III of HRS' Notice of Privacy Practices.* **My signature below confirms my receipt of HRS' *Notice of Privacy Practices* and my consent to the terms and conditions set forth in it.**

I authorize covered entities checked below to disclose PHI to Heart Rhythm Solutions (HRS), the office of Awais K. Humayun, and to receive PHI from HRS, the office of Awais K. Humayun (e.g., cardiac catheterizations, EKGs, pacemaker/monitoring/device reports / data, ECHO reports, stress tests, clinical/office notes, and any other healthcare data required for evaluation, treatment, or health insurance purposes). ****Required***

- ❑ Primary Care Physician* Name: ______________________ Phone: ______________
- ❑ Cardiologist* Name: ______________________ Phone: ______________
- ❑ Other Specialist Name: ______________________ Phone: ______________
- ❑ Other Medical Name: ______________________ Phone: ______________

Hospitals*

- ❑ Memorial Regional Hospital
- ❑ Memorial Hospital Miramar
- ❑ Memorial Hospital Pembroke
- ❑ Memorial Regional Hospital South
- ❑ Memorial Hospital West
- ❑ Florida Medical Center
- ❑ Jackson North Medical Center
- ❑ North Shore Medical Center
- ❑ Aventura Hospital & Medical Center
- ❑ Westside Regional Medical Center
- ❑ HCA Florida University Hospital
- ❑ Other: ______________________

______________________________ ______________________
Patient Name (Print) **DOB: (MM/DD/YY)**

______________________________ ______________________
Patient Signature **Date (Authorization valid for 1 year)**

______________________________ ______________________
PRINT (Legal Representative for Patient) Relationship to Patient

______________________________ ______________________
Signature (Legal Representative for Patient) Date (Authorization valid for 1 year)

4801 S University Drive, Suite 104 | Davie, Florida 33328 | P: (954) 707-5200 | F: (954) 526-4562 | heartrhythmsolutions.com

Revision: 5/18/2022

Awais K. Humayun, MD, FACC, FHRS

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DISCLOSE: I authorize the following **individuals, categories, or entities** checked below **to disclose protected health information (PHI) to Heart Rhythm Solutions (HRS), the office of Awais K. Humayun**, on the terms and conditions set forth in this authorization. If any box is checked, please identify persons, or class of persons authorized to disclose PHI to HRS.

- ❑ Family Members without Conservatorship (please specify): ______________________________________
____
- ❑ Residential and/or Community Programs (please specify): ______________________________________
____
- ❑ Psychological Services, Inpatient Psychiatric Hospitals (please specify): ___________________________
____
- ❑ HIV /other protected test results (please specify): ____
- ❑ Attorneys (please specify): ____
- ❑ Law Enforcement (please specify): ____
- ❑ Military (please specify): ____
- ❑ Other: ____

RECEIVE: I authorize the following individuals, categories, or entities checked below **to receive PHI about myself, and if necessary, my family from HRS, the office of Awais K. Humayun** on the terms and conditions set forth in this authorization.

- ❑ Family Members without Conservatorship (please specify): ______________________________________
____
- ❑ Residential and/or Community Programs (please specify): ______________________________________
____
- ❑ Other Medical/Therapeutic Services (please specify): ____
- ❑ Attorneys (please specify): ____
- ❑ Other: ____

_______________________________________ _______________________
Patient Name (Print) **DOB: (MM/DD/YY)**

_______________________________________ _______________________
Patient Signature **Date (Authorization valid for 1 year)**

_______________________________________ _______________________
PRINT (Legal Representative for Patient) Relationship to Patient

_______________________________________ _______________________
Signature (Legal Representative for Patient) Date (Authorization valid for 1 year)

Awais K. Humayun, MD, FACC, FHRS

Authorization for Disclosure of Protected Health Information

Preferred Primary Communication Methods

- ❑ Home phone: ______________________
- ❑ Mobile phone: ______________________
- ❑ Work phone: ______________________
- ❑ Other phone: ______________________
- ❑ Personal email: ______________________
- ❑ Work email: ______________________
- ❑ Other email: ______________________
- ❑ Different Billing Address: ______________________

____

____

Other preferred communication method (if primary method fails):

- ❑ Home phone: ______________________
- ❑ Mobile phone: ______________________
- ❑ Work phone: ______________________
- ❑ Other phone: ______________________
- ❑ Personal email: ______________________
- ❑ Work email: ______________________
- ❑ Other email: ______________________
- ❑ Other Method: ______________________

Other Communication Requests: ____

Patient Contacts: Florida law generally requires patient consent for entities to contact patients for purposes of providing information regarding treatment alternatives, services, or goods. If you request information that you have specified may be of interest to you regarding Heart Rhythm Solutions (HRS), Dr. Humayun, office activities, or services offered, explicit consent is required to contact you. Consent here for these communications, or as the need arises later.

- ❑ I consent to HRS contacting me for purposes of providing *information regarding treatment alternatives, services, activities, or goods, for which I have specified are of interest to me.*
- ❑ I do not consent.

Patient Communication Preferences: HRS will use the primary method(s) of contact you specify below. If none are specified, HRS staff will contact you at your home or mobile telephone number, and you will receive billing documents at your home address. This authorization expires 1-year after the signature date.

______________________________ ______________________

Patient Name (Print) **DOB: (MM/DD/YY)**

______________________________ ______________________

Patient Signature **Date (Authorization valid for 1 year)**

______________________________ ______________________

PRINT (Legal Representative for Patient) Relationship to Patient

______________________________ ______________________

Signature (Legal Representative for Patient) Date (Authorization valid for 1 year)

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Authorization for Disclosure of Protected Health Information

RECORDS RELEASE FORM

(FAX REQUEST TO MEDICAL PROVIDERS, FACILITIES, HOSPITALS, ETC.)

To:	**Patient:**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	**DOB:** ______________

Please be so kind as to send the following medical records for the above patient. This request and authorization applies to:

❑ **Healthcare Records:** ____

____

____

❑ **Other:** ____

____

____

Thank you for your help. Please fax this page back with the patient's medical records.

Upon signing, I agree to share any records pertaining to my medical care with Heart Rhythm Solutions | Dr. Awais K. Humayun, MD. This authorization expires 1-year after the signature date.

______________________	______________________
Patient Name (Print)	**DOB: (MM/DD/YY)**
______________________	______________________
Patient Signature	**Date (Authorization valid for 1 year)**
______________________	______________________
PRINT (Legal Representative for Patient)	Relationship to Patient
______________________	______________________
Signature (Legal Representative for Patient)	Date (Authorization valid for 1 year)

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Patient Registration Form (Please Print)

Patient Legal Name (First): ____________________ (Last): __________________________ Date: ___/____/____

Biological Gender: ❐ M ❐ F ❐ Ask Me Pronouns: ______________________ DOB:___/____/____

Gender Identity: ______________________________ Height:________________________ Weight: __________

Status: ❐ Single ❐ Married ❐ Divorced ❐ Separated ❐ Widowed ❐ Other: ____________________

Race: ❐ American Indian or Alaska Native ❐ Asian ❐ Black or African American ❐ White
❐Hispanic or Latino ❐ Native Hawaiian or Other Pacific Islander ❐ Unknown ❐ Other: ______________

Ethnicity: ❐ Hispanic or Latino ❐ Not Hispanic or Latino

Preferred Language: ❐ English ❐ Spanish ❐ ASL ❐ Other______________________________________

Do you have a living will? ❐ No ❐ Yes: Please provide a copy to the front desk

Address: ____

City/State: ___________________________________ Zip Code: ____________ Country: _________________

Primary Phone: (___)_________________________ OK to Leave Voicemail? ❐ Yes ❐ No

Mobile phone: (___)__________________________ ←OK to call? ❐ Yes ❐ No | Voicemail OK? ❐ Yes ❐ No

Would you like to receive automated-text messages from HRS? ❐ No ❐ Yes, Standard Rates Apply

Email Address: ____

Primary Care Provider (PCP): ____

PCP Phone: (___)______________________________ PCP Fax: (___)____________________________________

PCP Address: ____

Work Status: ❐ Full-Time ❐ Part-Time ❐ Student ❐ Retired ❐ Unemployed ❐ Other:______________

Employer's Name: ____

Work Phone: (___)____ ←OK to call? ❐ Yes ❐ No

Employers Address:____

Patient Insurance Information

Responsible Party: ❐ Self ❐ Family Member's Ins. ❐ Another Party ❐ Guarantor ❐ Other:___________

Relationship to Subscriber: ❐ Self ❐ ***Spouse** ❐ ***Child** ❐ ***Other:** ______________________________

Check here if Subscriber address and telephone information is same as the Patient ❐

Awais K. Humayun, MD, FACC, FHRS

Patient Registration Form (Please Print)

Patient Legal Name (First): __________________ (Last): ________________________ Date: ___/____/____

Primary Insurance Carrier: ___________________________ Ins. Co. Phone: (___) _________________________

Group Number: ___________________ Policy Number: ____________________ Start Date: __________

Insurance Type: ❒ HMO ❒ PPO ❒ Open Access ❒ Other: ____________________________________

PCP Referral Required? ❒ Yes ❒ No Specialist Copay: _________ Deductible: _________

***If relationship is Spouse, Child, or Other, also enter Subscriber information:**

Subscriber's First Name: ____________________ Last: __________________________ DOB: ___/___/____

Subscriber's Street Address: ____

City/State: _______________________________ Zip Code: ___________ Country: ________________

Subscriber's Phone: (___)_____________ Voicemail OK? ❒ Yes ❒ No Subscriber's Sex: ❒ M ❒ F

Secondary Insurance (*enter NA for not applicable*)

Secondary Insurance Carrier: ____________________________ Ins. Co. Phone: (___) _________________

Group Number: __________________________ Policy Number: _____________ Start Date: ____________

Secondary Insurance Type: ❒ HMO ❒ PPO ❒ Open Access ❒ Other: ___________________________

Relationship to Subscriber: ❒ Self ❒ *Spouse ❒ *Child ❒ *Other: ____________________________

PCP Referral Required? ❒ Yes ❒ No Specialist Copay: _________ Deductible: _________

***If relationship is Spouse, Child, or Other, also enter Subscriber information:**

Check here if Subscriber address and telephone information is same as the Patient ❒

Subscriber's First Name: ____________________ Last: __________________________ DOB: ___/___/____

Subscriber's Street Address: ____

City/State: _______________________________ Zip Code: ___________ Country: ________________

Subscriber's Phone: (___)_____________ Voicemail OK? ❒ Yes ❒ No Subscriber's Sex: ❒ M ❒ F

Referral Information (Required)

Patient's Referring Provider: ____

Patient's Referring Provider Address: ____

Telephone: (___) ____ Fax: (___) ____________________________

Patient's Cardiologist: __________________________________ Telephone: (___) _______________________

Awais K. Humayun, MD, FACC, FHRS

Patient Registration Form (Please Print)

Patient Legal Name (First): ____________________ (Last): __________________________ DOB:____/____/___

Cardiologist's Address: ____

Preferred Pharmacy (Required)

Patient's Pharmacy: ___________________________ Pharmacy Phone: (___)______________________________

Pharmacy Address: ____

Diagnosis

Diagnosis: 1. _________________________________ Diagnosis: 6. _______________________________________
Diagnosis: 2. _________________________________ Diagnosis: 7. _______________________________________
Diagnosis: 3. _________________________________ Diagnosis: 8. _______________________________________
Diagnosis: 4. _________________________________ Diagnosis: 9. _______________________________________
Diagnosis: 5. _________________________________ Diagnosis: 10. ______________________________________

Recent Hospitalizations

Recent Hospitalization? ❒ Yes ❒ No Date of last physical exam: ___________________________

Reason(s): ____

Hospital/Facility: _____________________________ Dates: ____

Cardiac Device History

Existing Cardiac Device? ❒ No ❒ Yes Device Type: ____

Manufacture: ❒ Medtronic ❒ St. Jude ❒ Boston Scientific ❒ Biotronik ❒ Sorin/ELA ❒ Unknown

Emergency Contact

In Case of Emergency (ICE) Person: ___________________________________ Phone: (____)_________________

Relationship: ____ Mobile: (____)_________________

Address: ____

General Patient Consent: I give permission for Heart Rhythm Solutions (HRS) | Awais K. Humayun, MD, FACC, FHRS to provide medical treatment and to file for insurance benefits to pay for the care I receive. I understand that: HRS will send my healthcare information to my insurance company for the purposes of treatment, payment, or healthcare operations. I must pay for the cost of services if my insurance does not pay, or if I do not have insurance. I must pay my share of insurance costs (co-pays, deductible, non-covered services, etc). I have the right to discuss all medical treatments with my physician, and to refuse any procedure or treatment.

Patient Signature (Required)

Signature of Patient (or Legal Representative)**:** ______________________________ **Date:** ___/____/____

Printed Name of Legal Representative: _____________________________________ **Date:** ___/____/____

Awais K. Humayun, MD, FACC, FHRS

Patient Registration Form (Please Print)

Patient Medical & Family History Questionnaire

Patient Name (First): ________________ (Last): ________________________ DOB: _____/____/____

Reason for Visit: ____

Immunizations/Dates: ❒ Hep B: _______ ❒ Influenza: _______ ❒ Meningococcal: _______ ❒ Tetanus: ❒

Others: ____

Previous Surgeries

❒ CABG (Coronary Bypass) ❒ Valve Replacement ❒ Defibrillator ❒ Cardiac Device

❒ Gallbladder ❒ Tonsillectomy ❒ Appendectomy ❒ Hernia

❒ Other: ____

Current Medical Problems

❒ Chest Pain ❒ Bleeding Disorder ❒ Heart Attack ❒ Heart Disease

❒ Hypertension ❒ Diabetes ❒ Cancer ❒ Kidney Disease

❒ Liver Disease ❒ Lung Problems ❒ Joint Disease ❒ Psychiatric Disorder

❒ Sleep Disorder ❒ Thyroid Disorder ❒ Skin Disease ❒ Stroke

❒ Ulcer ❒ Other: ____

Tobacco Use: ❒ Never ❒ Previous ~Start: _____________ ~End Date: ___________

❒ Current ➡Amount: _______ Pack/Wk Other Frequency: ______________________________

Alcohol Use: ❒ Never ❒ Previous ~Start: _____________~End Date: ___________

❒ Current ➡ Amount: ______(ounces) per Day / Week / Month (Circle) *Other* Frequency: __________

Illicit drug use in last 3-to 6-mo. (e.g., cocaine, heroin, methamphetamine, crack)? ❒ **Yes (Circle)** ❒ **No**

Family History

Is There a Family History of: ❒ Heart Attack ❒ Bypass Surgery ❒ Heart Rhythm Problems

❒ Heart Disease ❒ Cardiac Arrest ❒ Unexplained Fainting ❒ Other: ______________________

Father: ❒ Alive & Age:_______ ❒ Deceased at Age: _______ Due to: ___________________________

Medical Problems: ____

Mother: ❒ Alive & Age:_______ ❒ Deceased at Age: ____________ Due to: ____________________

Medical Problems: ____

Number of Siblings: ________ Medical Problems: _______________________________________

Number of Children: _______ Medical Problems: _______________________________________

heartrhythm solutions

Awais K. Humayun, MD, FACC, FHRS

Patient Registration Form (Please Print)

Medication & Allergies Information

Name (First): ______________________ (Last): ________________________ DOB:____/____/____

Pharmacy Name: ______________________ Phone: (   ) ______________ Fax: (   ) ______________

Pharmacy Address: ____

List allergic reactions to medications & other allergies that may affect your care.

Medication Allergies	Reaction

Include OTC, vitamins and other supplements, as well as alternative and herbal medications/tinctures

Medication & RX Start Date	Dosage	Frequency

Awais K. Humayun, MD, FACC, FHRS

Patient Registration Form (Please Print)

Review of Systems | Please check all that apply

Name (First): ____________________________ (Last): ____________________________ DOB:___/___/___

General
- ❑ Chills, Shakes
- ❑ Fevers
- ❑ Frequent Itchiness
- ❑ Significant Heat/Cold Intolerance
- ❑ Swollen Glands

Eyes
- ❑ Blurred Vision
- ❑ Cataracts
- ❑ Double Vision / Visual Disturbance
- ❑ Glaucoma

Ears
- ❑ Deafness
- ❑ Diminished Hearing
- ❑ Tinnitus (Ringing, Buzzing)

Mouth
- ❑ Dentures
- ❑ Gums Bleeding
- ❑ Poor Dentition

Cardiac
- ❑ Chest Pain: ________________________________
- ❑ Dizzy Spells
- ❑ Fainting Spells
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Waking Up Gasping for Air

Gastrointestinal: ______________________________
- ❑ Acid Reflux
- ❑ Bright Blood in Stool
- ❑ Black/Tarry Stools
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Poor Appetite
- ❑ Vomiting

Urologic
- ❑ Bladder Problems
- ❑ Burning with Urination
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Prostate

Kidneys
- ❑ Kidney Disease: _____________________________
- ❑ Kidney Stones

Lungs
- ❑ Asthma
- ❑ Cough
- ❑ Pain with Deep Breaths
- ❑ Wheezing
- ❑ Other: __________________________________

Joints: ____________________________________
- ❑ Stiffness
- ❑ Swelling
- ❑ Unusual Warmth

Extremities
- ❑ Leg Pain While Walking
- ❑ Varicose Veins
- ❑ Swelling

Mental Health: _______________________________
- ❑ Major Depression (or History)
- ❑ Severe Anxiety (or History)

Neurologic: _________________________________
- ❑ Arm/Leg Weakness
- ❑ Epilepsy/Seizures
- ❑ Significant memory loss
- ❑ Speech Difficulty
- ❑ Stroke: _________________________________
- ❑ Unsteady Gait (Walking)

Skin: ______________________________________
- ❑ Easy Bruising
- ❑ Rashes / Other: ___________________________

Awais K. Humayun, MD, FACC, FHRS

Patient Registration Form (Please Print)

GENERAL CONSENT FOR CARE AND TREATMENT

I give permission for Heart Rhythm Solutions | Awais K. Humayun MD PA to provide medical treatment and to file for insurance benefits to pay for the care I receive.

You have the right to be informed about your condition and recommended diagnostic tests, treatments, or surgical procedures to be used in your care. Plainly explaining recommendations with their associated benefits and risks is required so that you can make informed decisions to undergo or not undergo any suggested test, treatment, or procedure. At this point in your care, no specific treatment plan has been recommended.

You have the right to discuss your treatment plan with your physicians and ask questions about the purpose, potential risks, and benefits of any test ordered for you. This consent provides us with permission to perform reasonable and necessary medical exams, evaluations, and testing necessary to identify appropriate treatments and/or procedures for any identified condition(s). By signing below, you are indicating that: (a) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and, (b) you consent to treatment at this office, or any other HRS office / setting and /or affiliated hospital or medical facility. The consent will remain effective until it is revoked in writing. You have the right to discontinue services at any time. **Please check all that apply:**

- ☐ I voluntarily request Awais K. Humayun, MD, FACC, FHRS to perform any reasonable and necessary medical exams, testing, and treatment for the condition that has brought me to seek care at HRS.
- ☐ I voluntarily request a mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), to perform reasonable and necessary medical exams, testing, and treatment for the condition that brought me to seek care at HRS.
- ☐ I voluntarily request health care providers at Heart Rhythm Solutions, or their designees as deemed necessary, to perform reasonable and necessary medical exams, testing, and treatment for the condition that brought me to seek care at HRS.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Patient Name (Print)	**Date**
Patient Signature	**Date of Birth**
PRINT (Legal Representative for Patient)	**Relationship to Patient**
Signature (Legal Representative for Patient)	**Date**