FLORIDA HOSPITAL TRANSPLANT CENTER

CLINIC DEMOGRAPHIC INFORMATION

This application MUST be filled out completely.
ALL incomplete applications will be returned to sender

Name ____
(First) (MI) (Last) (Maiden)

Address ____
(Street) (Apt.)

____
(City) (State) (Zip) (County)

Phone Home ____________________ **Work** ____________________ **Cell** ____________________

Social Security Number____________________ **Date of Birth**______________ **Age**______ **Sex M / F**

Employer (Full time/Part time) ______________________________________ **Phone**____________________

Marital Status Single / Married / Divorced / Widowed / Separated
(Circle One)

Spouse/Significant Other Name ______________________________________

Phone Home ____________________ **Work** ____________________ **Cell** ____________________

***Is this person your first contact in case of emergency? Y / N**

Other Emergency Contacts

Name ________________________________
Phone Home ________________________
Work ________________________
Cell ________________________
Relationship ________________________

Name ________________________________
Phone Home ________________________
Work ________________________
Cell ________________________
Relationship ________________________

Height_________ **Weight**_________ **Visual Impairment: Y / N** **Hearing Impairment: Y / N**

Allergies:____

Education completed: (check one) **Grade school** _____ **College: 2 years** _____
High school _____ **College: 4 years**_____ **College:>4 years**_____

Race:____________________ **Hispanic Origin? Y/N** **U.S. Citizen? Y/N - if no, number of years in U.S.**____
Primary language spoken: English / Spanish / Other_________________
Can you read English? Y/N **Can you understand spoken English? Y/N**
If primary language is not English, who can we contact on your behalf that speaks English?

Name ______________________________________ **Phone** ______________________________________

<u>If you do not understand English, you will need to bring an interpreter to ALL appointments</u>

Referring Doctor ________________________ **NPI#**_____________ **Phone**__________________
Address ____ **Fax**__________________
Heart Doctor_____________________________ **NPI#**_____________ **Phone**__________________
Address ____ **Fax**__________________
Primary Care Doctor _______________________ **NPI#**_____________ **Phone**__________________
Address ____ **Fax**__________________

<u>For Office Use Only</u>:
Medical Record #: ______________________

Revised 06/23/2011

MEDICAL HISTORY

Diabetes Y / N
- Insulin Y / N
- Diabetic Medication Y / N — Age when diagnosed with diabetes_____

High Blood Pressure Y / N
Heart Disease Y / N
Tuberculosis Y / N
Stomach Ulcer Y / N
Seizures Y / N — Cause of seizure____
Treatment____

Hepatitis A Y / N
Hepatitis B Y / N
Hepatitis C Y / N — Have you received treatment for Hepatitis B or C? Y/N
Have you had a liver biopsy done for Hepatitis B or C? Y/N
Doctor who treated you for Hepatitis ___________________________

Blood Transfusions Y / N — How many? _____ Date of last transfusion ____________________
Would you be willing to receive blood if needed? Y / N

Cancer Y / N — When: ____
Type of Cancer____
Treatment ____
Doctor who treated Cancer____________________________________

*****PATHOLOGY REPORTS FROM ALL CANCERS MUST BE INCLUDED WITH APPLICATION******

Surgery: (Please list any surgeries you have had with the approximate dates)

Type of Surgery	Date of Surgery/Hospital
CABG	
Aortic Valve	
Mitral Valve	
ICD/Pacemaker (please list type)	
Stents	
Other:	
Other:	

Do you smoke? Y/N
Did you ever smoke? Y/N
If yes, how long?____ Date quit___________________
Have you ever used recreational drugs? Y/N
Do you currently use recreational drugs? Y/N
Name of recreational drugs used____
Do you drink alcohol? Y/N
If yes, how often?___________________
Are you seeing a mental health specialist? Y/N
Are you taking medication for anxiety and/or depression? Y/N
Name of medications:____

For Females

Number of pregnancies:____
Is it still possible for you to become pregnant? Y/N
If yes, type of birth control being used____

MEDICAL HISTORY

What caused your heart to fail? ____

Have you been told that your kidneys are not working because of the heart failure? Y/N

Current heart failure treatment ____

TRANSPLANT HISTORY

Have you had a previous organ transplant? Y/N
If yes, complete the following information:

Type of Transplant ______________________________

Transplant Center ______________________________

Date of Transplant ______________________________

Transplant Doctor ______________________________

Living Donor / Deceased Donor
(circle one)
***If living, Name of Donor:_____________________Relationship:_____________________**

APPLICATION CHECKLIST

If the application is incomplete, it will be returned to the sender. Please read complete list. The following information MUST be included in order for the application to be complete:

___ Cardiologist's History and physical- typed copy
___ Current office notes/progress notes from Cardiologist's office
___ Recent labs from Cardiologist's office or Primary Office
___ Copies of Insurance cards and drug coverage cards: front and back
___ Completed Insurance Information sheet (page 4)
___ Pathology reports and treatment records for any patient with a history of cancer
___ Cardiac catheterization results (if done)
____ Echocardiogram results
___ Chest x-ray and/or CAT scans (if done)

I have completed the application and enclosed all necessary reports on the checklist. I understand that laboratory/diagnostic testing and psychosocial evaluation will be done during my heart transplant evaluation.

Patient Signature______________________________Date_________________________

Name of person who assisted you with completing this application______________________________

Return application to: **Florida Hospital Transplant Center**
2415 N. Orange Ave, Suite 700
Orlando, FL 32804

Insurance Information

Include copies of Insurance cards and Drug cards-front and back.

Patient Name______________________________SocialSecurity#___________________________

MEDICARE INFORMATION

Medicare Number________________________ Primary / Secondary / Tertiary / Pending
Part A Effective Date ____________________ (Circle one)
Part B Effective Date ____________________
Date Medicare became Primary__________________
If not currently on Medicare, are you Medicare eligible? Y/N

MEDICAID INFORMATION

Medicaid Number________________________ Primary / Secondary / Tertiary / Pending
(Circle one)
Medically Needy: Y/N If yes, Share of Cost Amount_________________________________

OTHER INSURANCE

Primary / Secondary / Tertiary / Pending
(Circle one)

Insurance company name:____________________________________ Phone____________________
ID Policy #____________________________ Group #______________________________________
Policy Type (Circle One) **HMO PPO POS Indemnity Other_____________________________**
Employer / Group Name____
Insured's Name ______________________________________ Relationship to patient_____________
Insured's Social Security #____________________ Insured's Date of Birth____________________
Primary Care MD_____________________Phone________________Fax_______________________
Is this a COBRA policy? Y / N Effective date________________ Termination date______________
Insurance Premiums are paid by:____

OTHER INSURANCE

Primary / Secondary / Tertiary / Pending
(Circle one)

Insurance company name:____________________________________ Phone:____________________
ID Policy #____________________________ Group #______________________________________
Policy Type (Circle One) **HMO PPO POS Indemnity Other_________________________________**
Employer / Group Name____
Insured's Name ______________________________________ Relationship to patient_____________
Insured's Social Security #____________________ Insured's Date of Birth____________________
Primary Care MD______________________Phone_________________Fax_____________________
Is this a COBRA policy? Y / N Effective date________________ Termination date______________
Insurance Premiums are paid by:____

PRESCRIPTION DRUG COVERAGE

My prescription drug coverage is through:

__Medicare Part D: ________________(Name of Company) **Phone#_______________ID#______________**
__Private Insurance________________(Name of Company) **Phone#_______________ID#______________**
__Medicaid
__VA Location________________________ Phone__________________________

Retail/Brand name co-pay $______ Generic co-pay $______ Mail order$______ Maximum benefit $__________

Florida Hospital Transplant Center
Financial Agreement

Organ transplantation is an expensive undertaking that requires a serious commitment. It represents a partnership between you, your physicians, and the transplant team. How you are going to pay for the transplant and necessary on-going care and medications should not be an additional burden that you should be facing.

Therefore, it is important for you to understand the terms and conditions of your current insurance and keep apprised of any changes that may occur with your insurance coverage. Initially, our Financial Coordinator will verify your insurance benefits and determine coverage for transplant here at Florida Hospital. She will periodically contact you and/or your insurance company to determine any changes in coverage. However, it remains YOUR RESPONSIBILITY to be aware of any changes to your insurance coverage and to notify our Financial Coordinator of those changes, in writing, within one week of the change. A copy of the new insurance card must be sent to us, along with a legible phone number so that we may contact your new insurer to verify transplant benefits at our facility. Failure to do this may jeopardize your ability to receive a transplant at Florida Hospital.

If you elect to change coverage, it is important to ensure that you select an insurance company that will cover your transplant at Florida Hospital, your follow-up care and subsequent medication needs.
Ultimately, YOU are financially responsible for the medical services you receive. If your insurance company does not cover transplant services here, or if there is a co-pay or deductible, which is not covered by Medicare or your group plan, then you will be financially responsible for these payments. Accordingly, it is pivotal for you to maintain uninterrupted insurance coverage and ensure that your new insurance will reimburse your care adequately and underwrite the cost of your ongoing medical needs.

Our Financial Coordinator can advise you on which insurance plans provide adequate coverage, as well as explain Medicare regulations as they pertain to End Stage Heart Disease. Our Social Worker can advise you on state Medicaid regulations and eligibility requirements. We STRONGLY advise transplant patients to opt for **Medicare Part B**, as well as Part A once their Medicare eligibility begins.

If you have any questions or concerns regarding the financial aspects of your heart transplant, please contact the
Transplant Financial Coordinator, at 407 303-2474.

Please sign and date the agreement below and return it to Florida Hospital Transplant Center along with the rest of your application packet. Thank you.
You may wish to make a copy of this for your records.

AGREEMENT:

I understand that financial approval is based on my current insurance benefits and eligibility. If any changes occur to my insurance coverage, I agree to notify Florida Hospital Transplant Center within one week of the change. My failure to do so can result in an insurance denial and/or my personal liability for any and all charges associated with the procedure. My signature below authorizes Florida Hospital Transplant Center to release information for purposes of obtaining approval for my transplant.

I understand and accept the terms of this financial agreement.

______________________________ ______________________
PRINT NAME DATE OF BIRTH

______________________________ ______________________
PATIENT'S SIGNATURE DATE