Julie J. Ramos MD. PA.
Cardiovascular & Vein Center

1720 SE 16th Ave, Bldg 300, Ste 303
Ocala, FL 34471 (352)306-6390
manager@drjramos.com

PERSONAL INFORMATION

First Name: _____MI ____ Last Name: _____

SSN: _____-_____-_____ DOB: _____-_____-_____ Sex: Male ___ Female ___

Home Address: _____

City: _____ State: _____ Zip _____

Home # _____-_____-_____ Mobile # _____-_____-_____ Work # _____-_____-_____

Email address: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Phone: _____-_____-_____

Patient's Relationship to Emergency Contact: _____

EMPLOYMENT INFORMATON

□ Full-time □ Part-time □ Retired □ Other

Employer Name: _____ Title: _____

Employer Address: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID# _____
Guarantor Name: _____ Guarantor DOB: _____

Secondary Insurance Company: _____ ID# _____
Guarantor Name: _____ Guarantor DOB: _____

MEDICAL INFORMATION

Primary Care Provider: _____ Phone # _____

Previous Cardiologist: _____ Phone # _____

Primary Pharmacy: _____ Phone: _____

Secondary Pharmacy: _____ Phone: _____

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MEDICATIONS

Medication Name	Medication Strength	# of Pills/Day

MEDICAL HISTROY

Tobacco Use: Yes/No? _____ Date Quit: _____ Current Smoker: Packs/Day: _____ # of Years: _____

Alcohol: Yes/No? _____ Date Quit: _____ Drinks/Day: _____ # of Years: _____

Any known allergies: _____

Are you under the care of any other Physician: _____
If yes, please list other physicians and what is being treated:

_____
_____
_____
_____
_____
_____
_____
_____

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AUTHORIZED REPRESENTATIVE

This section is used to confirm a patient's permission for Julie J. Ramos, MD PA, to discuss or disclose their protected health information (PHI) to a particular person who acts as their authorized representative. Use of patient information is limited strictly to that purpose described above.

Please note, this authorization does not provide your Authorized Representative with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a Health Care Partner/Proxy or Clinical Personal Health Care Representative, or if you want to set up a living will, please discuss with your Primary Care Physician and/or attorney. Also, we promise that we will not condition treatment on the execution of this form.

Personal Health Information (PHI), including but not limited to, billing information, diagnosis, procedures, demographic information (not including psychotherapy notes).

I understand that your general policy is not to disclose my PHI to other parties except those directly involved in my care, without my written authorization, or as permitted or required by law. For this reason, I authorize you to discuss and disclose my PHI to the person(s) named below in this section (section C) for the purpose of assisting with, of facilitating the coordination or payment of my health care. I also understand that if my authorized representative is not a health care provider, or another entity subject to federal or application and privacy laws, and my personal healthcare representative may further disclose my PHI without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative Name: _____

Address: _____

Phone: _____ Relationship: _____

Authorized Representative Name: _____

Address: _____

Phone: _____ Relationship: _____

By signing this form, I understand that Julie J. Ramos, MD PA may release my personal health information as described above to my authorized representative (s).

_____ _____

Patient or Representative Signature Date Signed

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CONSENT FOR USE/DISCLOSURE OF INFORMATION

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Julie J. Ramos, MD, PA, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Julie J. Ramos, MD, PA's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Julie J. Ramos, MD, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Privacy Officer
Julie J. Ramos, MD, PA
1720 SE 16th Ave, Bldg 300, Suite 303
Ocala, FL 34471

With my consent, Julie J. Ramos MD, PA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and employee statements, if they are marked Personal and Confidential.

By signing this form, I am consenting to Julie J. Ramos, MD, PA use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Julie J. Ramos, MD, PA may decline to provide treatment to me.

I attest that the above information is true to the best of my knowledge.

_____ _____

Patient or Representative Signature Date

Julie J. Ramos MD. PA.
Cardiovascular & Vein Center

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AUTHORIZED RELEASE OF MEDICAL RECORDS

Patient's Name: _____ SSN: _____-_____-_____ DOB: _____-_____-_____

Address: _____

City: _____ State: _____ Zip _____

Phone # _____-_____-_____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above-named patient. Date(s) of service _____

Patient information is needed for:

( ) Continuing medical care ( ) Military ( ) Social Security/Disability ( ) Insurance ( ) Personal Use ( ) Legal Purposes

( ) School ( ) Other _____

Information to be released or accessed:

( ) ALL RECORDS ( ) History & Physical ( ) ER Report ( ) Entire Record ( ) Progress Note ( ) Cardiac/EKG
( ) Medication List ( ) Lab Note ( ) Operative Report ( ) X-Ray Reports ( ) Other
_____

The above information may be released to (please specify name or title of individual, or name of organization to which records should be released to with address and phone number):

TO:_____

Phone #: _____ Fax::_____

Address: _____

From: _____

Phone #: _____ Fax::_____

Address: _____

As required by State and Federal Law, Julie J, Ramos, MD, PA may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates you are giving permission for the use and disclosure of the Protected Health Information described on this form. I understand that State Law prohibits the redisclosure of the information disclosed to the person(s) listed above without further authorization, but that Julie J. Ramos, MO, PA cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition. This disclosure will remain in effect for 12 months or until I revoke it in writing by writing to Julie J. Ramos MD, PA, Compliance Officer.

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I understand that such revocation does not refer to the information already released in response to this authorization. I understand that I am not obligated to sign this form and I have the right to inspect and to obtain a copy of any information disclosed. I hereby release Julie J. Ramos, MO, PA, and its employees, from all liabilities that may arise from the release of information as I have directed. I understand that I may be charged a fee of up to one dollar (Sl.00} per page, (plus applicable tax and handling} for every page copied. This fee is waived (or copies provided to a health care provider for continuing medical care. I understand this fall within the limits allowable by Florida Law.

_____ _____

Patient or Representative Signature Date

_____ _____

Printed name of patient or legally authorized representative Relationship to patient

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PRACTICE FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. To achieve this goal, I need your assistance and your understanding of my payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED.

My office accepts cash, personal checks, Visa and Mastercard. Returned checks less than $50.00 are subject to a service charge (per Florida statue 832.80) of $25.00. The service charge for returned checks between $50.00 and $300.00 is $30.00. For checks greater than $300.00, the return service charge is $40.00. Also, you will lose your privilege to write for my office. **MISSED/CANCELLED APPOINTMENTS HAVE A SERVICE CHARGE OF $50.00. MISSED/CANCELLED STRESS TESTS HAVE A SERVICE CHARGE OF $250.00 (including cancellation due to not following stress test instructions, no caffeine, etc.)**. You must call our office **at least 24** hours in advance to reschedule an appointment and to avoid service charges. Patients who do not show up for their appointments will be discharged from the practice after 3 **no-shows**.

BLUE CROSS & BLUE SHIELD PPC COVERAGE co-payments and deductibles are due at time of service.

MEDICARE deductibles are due at the time of service. If you already paid your deductible (please bring your EOB showing you have met your deductible), and if Medicare is your only coverage, we will charge you 20% of the Medicare allowable charges. Since I am a Medicare provider, I will file your Medicare claim. If you have a secondary insurance company of which I am a provider, I will file your claim with the secondary and then bill you for the remaining balance of allowable charges. If you have secondary insurance, please check with your insurance billing department to see if I file with that company. If I do not know the allowable charge for a specific service, I will bill you after Medicare pays.

FINANCIAL AGREEMENT My office and I are happy to discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that: (1) your insurance is a contract between you and your employer if applicable, and the insurance company. My office and I are not part of that contract. (2) Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover (like yearly physicals. I must emphasize that as your medical care provider, my relationship and concern is with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. If payment has not been received from your insurance company after 90 days, you may be responsible for paying the amount due. I realize that emergencies do arise and may affect the timely payment on your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.
If it becomes necessary to collect any sum due through an attorney, then you, as the patient, agree to pay all reasonable costs of collection, including attorney fees, whether suit is filed or not. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you.

I HAVE READ AND UNDERSTOOD THE ABOVE PATIENT FINANCIAL POLICY. I UNDERSTAND MY CREDIT /DEBIT CARD WILL BE KEPT ON FILE FOR USE BY OUR OFFICE.

_____ _____

Patient or Representative Signature Date

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NOTICE OF PRIVACY PRACTICE

Effective Date: January 1, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

At Julie J. Ramos, MD, PA, we understand that your health information is personal. We are committed to protecting your medical information and complying with all applicable privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

How We May Use and Disclose Your Health Information

We may use and share your medical information in the following ways:

1. Treatment

We may use your health information to provide, coordinate, or manage your cardiac care. This includes sharing information with other healthcare providers involved in your care (e.g., primary care physicians, specialists, hospitals).

2. Payment

We may use and disclose your information to bill and receive payment from health plans, insurance companies, or other third parties.

3. Healthcare Operations

We may use your information to run our practice, improve care quality, train staff, and conduct administrative activities.

Other Permitted Uses and Disclosures

We may also disclose your information:

- As required by law (e.g., public health reporting)
- For health oversight activities (e.g., audits, inspections)
- For law enforcement purposes
- To avert a serious threat to health or safety
- For workers' compensation claims
- In response to court orders or legal processes

Uses and Disclosures Requiring Your Authorization

We will obtain your written permission before:

- Sharing office notes (if applicable)
- Using your information for marketing purposes
- Selling your health information

You may revoke your authorization at any time in writing.

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Your Rights Regarding Your Health Information

You have the right to:

- **Access** your medical records
- **Request corrections** to your records
- **Request restrictions** on certain uses or disclosures
- **Request confidential communications**
- **Receive a list** of disclosures we have made
- **Obtain a paper copy** of this notice

Our Responsibilities

We are required to:

- Maintain the privacy and security of your health information
- Provide you with this notice
- Follow the terms of this notice
- Notify you if a breach of your unsecured health information occurs

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Changes to This Notice

We reserve the right to update this notice at any time. Any changes will apply to all information we have about you. Updated notices will be available in our office and upon request.

Contact Information

If you have questions about this notice or believe your privacy rights have been violated, please contact:

Privacy Officer

Julie J Ramos
1720 SE 16th Ave
Building 300, Suite 303
Ocala, FL 34471
352-306-6390
curtis@drjramos.com

You may also file a complaint with the U.S. Department of Health and Human Services. Filing a complaint will not affect your care.

I acknowledge that I have received Julie J. Ramos, MD, PA's Notice of Privacy Practices. I have had the full opportunity to read and consider the contents of this Notice of Privacy Practices.

_____ _____

Patient or Representative Signature Date