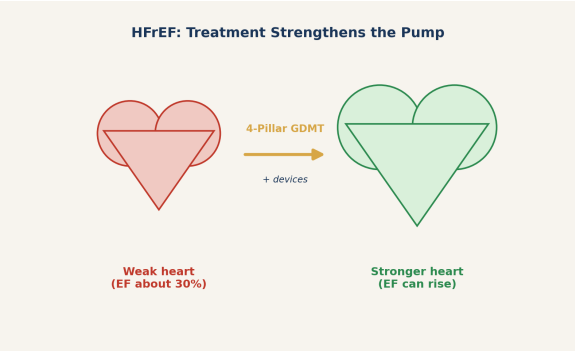
Understanding HFrEF

Heart Failure with Reduced Ejection Fraction

Your heart's pump is weak — but it can grow stronger.



Online: https://go.riasalimd.com/hf-guide

Rias KS Ali, MD FACC

Board Certified in Interventional Cardiology & Cardiovascular Disease

4740 Mile Stretch Drive, Holiday FL 34690 | Office: (727) 943-5200 | Fax: (727) 943-5201 | RiasAliMD.com

Last Updated: August 2026

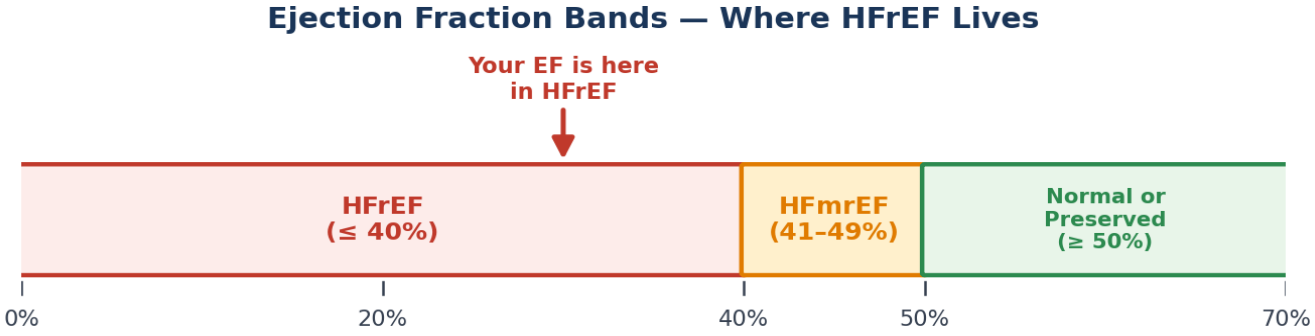
Names & Terms You Will Hear

Term	Meaning
HFrEF	Heart Failure with reduced Ejection Fraction — the medical name.
Systolic heart failure	Older term — the squeeze (systolic) phase is weak.
Congestive heart failure (CHF)	Umbrella term covering HFrEF and HFpEF, often used when fluid backs up.
Cardiomyopathy	Any disease of the heart muscle that weakens the pump.
Ischemic cardiomyopathy	HFrEF caused by coronary artery disease or a prior heart attack.
Non-ischemic cardiomyopathy	HFrEF from any non-CAD cause (viral, alcohol, chemo, genetic).
Low EF / weak pump	Informal terms for the same condition.
Ejection fraction (EF)	The percent of blood pumped out with each heartbeat.
NYHA Class I-IV	How we rate symptoms (no symptoms to symptoms at rest).

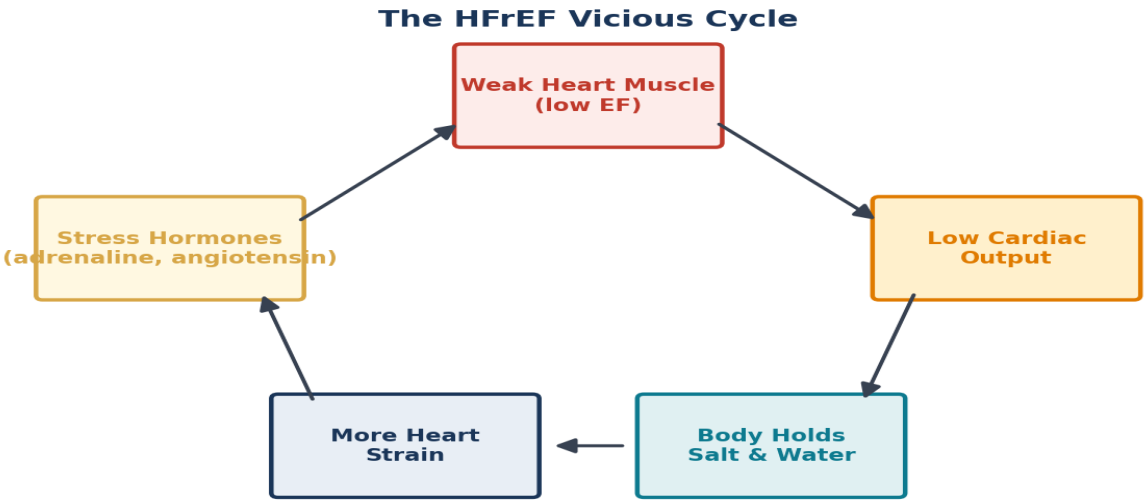
Call 911 now if you have sudden severe shortness of breath, chest pain, pink or frothy mucus, fainting, or an ICD shock with new symptoms. **Do not drive yourself.**

What Is HFrEF?

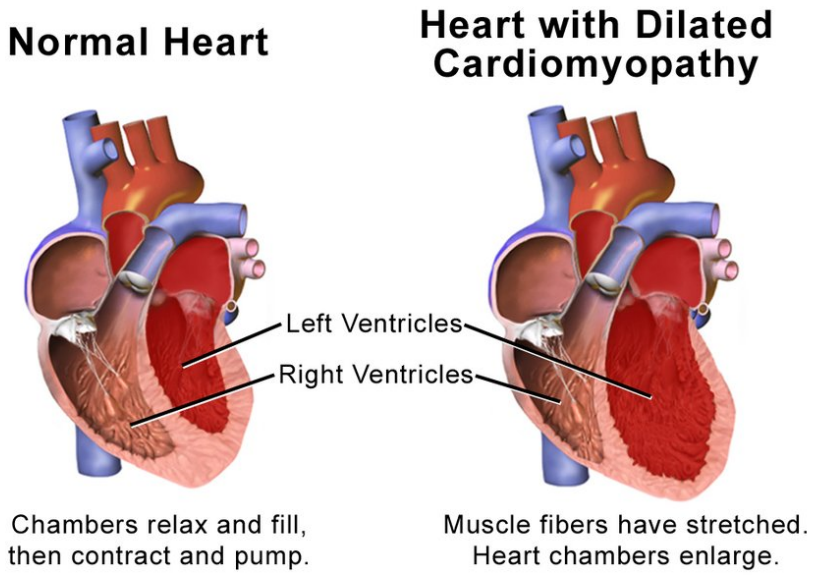
- HFrEF means the heart muscle is weak. Heart failure does NOT mean the heart has stopped.
- Ejection fraction (EF) is the percent of blood pumped out each beat. Normal or preserved EF is 50% or higher (a typical healthy range is about 55 to 70%). HFrEF is an EF of 40% or lower.
- The most common cause is coronary artery disease, often after a heart attack.
- Other causes: long-standing high blood pressure, viral infection, alcohol, chemotherapy, and genetic forms.
- About 3 million Americans live with HFrEF.
- EF can improve with the right treatment. Many patients see their EF rise by 10 to 20 points within 6 to 12 months.
- Modern medicines can add years of life and cut hospital stays in half.



Ejection fraction bands. HFrEF lives in the red zone (40% or lower). With GDMT, many patients see their EF rise out of the red zone within 6 to 12 months.



The HFrEF vicious cycle. A weak heart triggers stress hormones and fluid build-up, which strain the heart even more. GDMT breaks the cycle at every node — that is why all four pillars are used together.



A normal heart next to one with dilated cardiomyopathy. In the weak heart the main pumping chamber has stretched and enlarged, so each beat pushes out less blood. Image credit: BruceBlaus, Wikimedia Commons (CC BY 3.0).

Why It Matters

- Untreated HFrEF leads to repeated hospital stays and a shorter life span.
- The biggest risk is sudden cardiac death from a fast heart rhythm. An ICD saves lives when the EF stays low.
- The 4 pillars (ARNI, beta-blocker, MRA, SGLT2 inhibitor) cut CV death and HF hospital stays by more than half.
- Most patients feel better within 4 to 12 weeks of starting GDMT. Less breathlessness, more energy, less swelling.
- Cardiac rehab cuts death and re-hospitalization by about 25%. Medicare covers it after an HF event.
- Taking all four medicines daily is the single biggest predictor of survival.

NYHA Functional Class — Symptoms by Severity

NYHA Class	Symptoms	What you can typically do
Class I	No symptoms	Ordinary activity (walking, stairs, work) without limits.
Class II	Mild symptoms with ordinary activity	Comfortable at rest. Stairs or brisk walking cause mild breathlessness.
Class III	Marked limits with less than ordinary activity	Comfortable at rest. Short walks or light housework bring symptoms.
Class IV	Symptoms at rest	Any activity worsens breathlessness. Often unable to leave home alone.

Causes of HFrEF — Why the Pump Got Weak

- **Ischemic (most common):** a prior heart attack leaves scar tissue that cannot squeeze. Even small or silent heart attacks can lower EF.
- **High blood pressure:** years of high pressure first thicken, then weaken the muscle.
- **Viral infection (myocarditis):** a virus inflames the heart. Some patients recover; some are left with HFrEF.
- **Alcohol:** heavy drinking for years can weaken the muscle. Partly reversible if you stop early.
- **Chemotherapy:** some cancer drugs harm the muscle. We screen with echo during and after treatment.
- **Family history:** dilated cardiomyopathy can run in families. Tell us about HF or sudden death in relatives.
- **Fast rhythm for too long:** uncontrolled AFib can weaken the muscle. Rate or rhythm control reverses this in many patients.
- **Valve disease:** severe aortic stenosis or mitral regurgitation can drive HFrEF. Fixing the valve can lift the EF.
- **Idiopathic:** sometimes we cannot find a cause — the treatment is the same.

EF can improve. Many patients see their EF rise by 10 to 20 points within 6 to 12 months. A patient who starts at 25% may reach 40% or higher. This is called *HF with recovered EF*. Keep taking your medicines to hold the gain.

NYHA Class At a Glance — Where Are You?

Class I	Class II	Class III	Class IV
• No symptoms	• Mild symptoms with effort	• Symptoms with light activity	• Symptoms at rest
• Normal activity tolerated	• Comfortable at rest	• Comfortable at rest	• Any activity worsens them
• Continue all 4 GDMT pillars	• Optimize GDMT to target doses	• Re-check EF; consider ICD/CRT-D	• Advanced HF referral
• Focus on prevention	• Cardiac rehab helps	• Close follow-up needed	• Discuss goals of care

Risk Factors

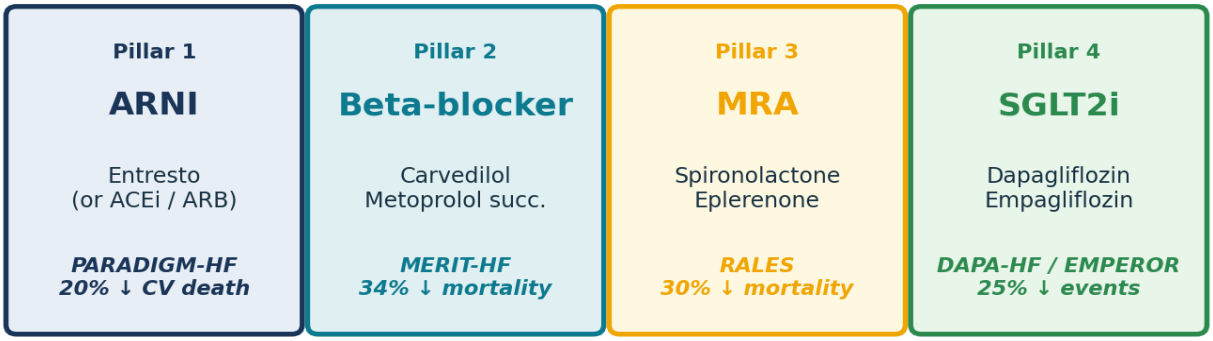
Some patients are more likely to develop this condition. Knowing your risk helps your care team take extra precautions.

Risk Factor	Why It Increases Risk
Prior heart attack or CAD	The #1 cause of HFrEF in the US. Scar tissue from a heart attack weakens the squeeze.
Long-standing high blood pressure	Years of high pressure first thickens, then weakens the heart muscle.
Viral infection of the heart	Some viruses (including COVID) can inflame the heart. The damage is sometimes long-lasting.
Heavy alcohol use	Three or more drinks a day for years can weaken heart muscle. Partly reversible if you stop early.
Chemotherapy	Some cancer drugs harm heart muscle. We screen with echo during and after treatment.
Family history	Dilated cardiomyopathy can run in families. Tell us if a close relative had HF or sudden death.
Uncontrolled atrial fibrillation	A fast heart rate for weeks or months can weaken the muscle. Rate or rhythm control reverses this in many patients.
Diabetes	Doubles HF risk. SGLT2 inhibitors and GLP-1 drugs lower that risk on top of sugar control.
Sleep apnea	Untreated apnea raises BP and worsens HFrEF. CPAP helps.
Severe valve disease	Aortic stenosis or mitral regurgitation can drive HFrEF. Repair or replacement can reverse it.

Treatment Options

- **Pillar 1 - ARNI (Entresto)**. First choice. If not tolerated, use an ACE inhibitor (lisinopril) or an ARB (losartan).
- **Pillar 2 - Beta-blocker**. Carvedilol, metoprolol succinate, or bisoprolol. Start low, go slow.
- **Pillar 3 - MRA**. Spironolactone or eplerenone. Removes extra fluid and protects the muscle. Needs potassium checks.
- **Pillar 4 - SGLT2 inhibitor**. Dapagliflozin or empagliflozin. Works whether or not you have diabetes.
- **Diuretic** (furosemide, torsemide). Relieves congestion. Dose adjusts to your daily weight.
- **Vericiguat (Verquvo)**. Add-on for worsening HFrEF after a recent hospital stay.
- **Hydralazine + nitrate**. Cuts mortality 43% in Black patients (A-HeFT). Also used when ACEi or ARB cannot be used.
- **ICD** if EF stays at or below 35% after 3 months of GDMT. Protects from sudden death.
- **CRT-D** when QRS is wide (150 ms or more) with LBBB. Re-syncs the heart and adds ICD.
- **LVAD or transplant**. For stage D HFrEF when medicines and standard devices are not enough.
- **Cardiac rehab**. Supervised exercise plus education. Cuts death and re-hospitalization by 25%.
- Never stop a heart medicine on your own. Sudden stops can trigger a flare.

The Four Pillars of GDMT for HFrEF



The four pillars of GDMT and the landmark trials that earned each its place. Used together, these medicines cut CV death and HF hospital stays by more than half.

When to Add a Device — Step by Step

Step 4	**Advanced HF therapy** LVAD or transplant for stage D symptoms that persist.
Step 3	**ICD or CRT-D implant** ICD if EF 35% or lower (SCD-HeFT). Add CRT if QRS 150 ms or more with LBBB.
Step 2	**Recheck EF on echo** If EF still 35% or lower, you may qualify for an ICD or CRT-D.
Step 1	**4-pillar GDMT for 3 months or more** Maximum tolerated doses of ARNI/ACEi, beta-blocker, MRA, SGLT2i.

Devices are added in steps — first GDMT for at least 3 months, then recheck EF, then ICD or CRT-D if EF stays low. Advanced therapies (LVAD, transplant) come last.

GDMT Pillars — Trial Evidence at a Glance

Pillar	Drug examples	Key benefit	Landmark trial
1 — ARNI / ACEi / ARB	Entresto, lisinopril, losartan	20% lower CV death	PARADIGM-HF
2 — Beta-blocker	Carvedilol, metoprolol succ., bisoprolol	34% lower death rate	MERIT-HF / CIBIS-II
3 — MRA	Spironolactone, eplerenone	30% lower death rate	RALES / EMPHASIS-HF
4 — SGLT2 inhibitor	Dapagliflozin, empagliflozin	25% lower HF hosp. + CV death	DAPA-HF / EMP EROR-Reduced

Medication Monitoring — What We Check, How Often

Medication	What to monitor	How often
ARNI / ACEi / ARB	BP, kidney function, potassium	Every 1 to 3 months at dose changes
Beta-blocker	Heart rate, BP, symptoms	Every visit
Spironolactone / eplerenone	Potassium, kidney function	Every 2 to 4 weeks when starting
SGLT2 inhibitor	Kidney function, blood sugar (if diabetic), UTI symptoms	Now and then
Diuretic (furosemide, torsemide)	Daily weight, potassium, kidney function	Weight daily; labs monthly

Add-On Therapies — Beyond the Four Pillars

- **Vericiguat (Verquvo):** add-on for worsening HFrEF after a recent hospital stay (VICTORIA trial). See our Verquvo guide.
- **Hydralazine + nitrate:** cut deaths 43% in Black patients (A-HeFT). Also used when ACEi or ARB cannot be used.
- **Ivabradine:** lowers heart rate when sinus rhythm stays above 70 on a max beta-blocker dose.
- **Digoxin:** for select patients with stubborn symptoms or AFib. Helps symptoms; does not lower the death rate.
- **IV iron:** patients with HFrEF and iron deficiency feel better and stay out of hospital more on IV iron.
- **WCD (LifeVest):** a vest that watches for VT or VF in the first 90 days while EF may still recover. See our WCD guide.
- **Diabetes drugs:** SGLT2 inhibitors and GLP-1 drugs lower heart risk on top of sugar control. See our SGLT2 guide and Diabetes and the Heart.

Devices — ICD, CRT-D, and Advanced Therapies

- **ICD:** a matchbox-sized device under the skin. It watches the rhythm 24/7. If VT or VF happens, it gives a quick shock to reset the heart. Used when EF stays at or below 35% on 3 or more months of GDMT. SCD-HeFT cut deaths 23%.
- **CRT (biventricular pacemaker):** re-syncs both sides of the heart. Best when EF is 35% or lower and QRS is wide (150 ms or more) with LBBB. CARE-HF showed lower death rates. Most eligible patients get a combined CRT-D. See our ICD and CRT-D guide.
- **His or LBB-area pacing:** a newer option for some patients. Ask if you might qualify.
- **LVAD:** a mechanical pump in the chest that takes over the left ventricle's work. For stage D HFrEF — bridge to transplant or long-term therapy.
- **Heart transplant:** for stage D HFrEF when medicines and standard devices fall short. Selection is strict. Adds years of life when matched.
- **Goals-of-care talk:** advanced HFrEF planning. We help with this and refer to palliative care when needed.

Daily Self-Care — Weights, Salt, Fluids, Movement

- **Daily weight:** same time, same scale, after the bathroom and before eating. Write it down. Bring the log to every visit.
- **Sodium under 2,000 mg/day:** read every label. Restaurant and packaged foods hide the most salt.
- **Fluids 1.5 to 2 liters/day:** count water, coffee, soup, ice cream, popsicles. Use a marked bottle.
- **No alcohol:** it weakens heart muscle and can trigger AFib.
- **Exercise:** start with cardiac rehab if offered. Then walk most days. Start slow and build.
- **Sleep apnea:** use your CPAP every night.
- **Vaccines:** flu and pneumonia shots on schedule. Infection is a top trigger of HF hospital stays.
- **Carry your medicine list:** show it to every dentist, surgeon, and ER doctor.

Where HFrEF Fits with Your Other Care

- HFrEF rarely travels alone. Most patients also need care for the conditions below — and each has its own guide.
- Heart attack and ACS: see our Heart Attack (ACS) guide.
- Coronary artery disease: see our CAD guide.
- Diabetes and the heart: see our Diabetes and the Heart guide.
- Cardiac rehab: see our Cardiac Rehab guide.
- ICD and CRT-D: see our ICD and CRT-D guide.
- SGLT2 inhibitors: see our SGLT2 guide.
- Vericiguat (Verquvo): see our Verquvo guide.
- Bempedoic acid (LDL drug): see our Bempedoic Acid guide.
- HFpEF (the 'other' heart failure): see our HFpEF guide.
- Diastolic dysfunction: see our Diastolic Dysfunction guide.

Start all four pillars early. Newer evidence supports starting all four pills together when BP and kidneys allow. A faster start means earlier benefit.

Daily Weight Self-Management — Know Your Zone

GREEN — Stable	YELLOW — Caution	RED — Emergency
• Weight stable (within 2 lb)	• Weight up 3 lb in 2 days OR 5 lb in a week	• Weight up more than 5 lb in 2 days
• Breathing as usual	• Mild new shortness of breath	• Breathless AT REST or cannot lie flat
• No new ankle swelling	• Mild new ankle / sock-line swelling	• Chest pain, fainting, confusion, ICD shock
• ACTION: continue all meds; daily weights; low-salt diet; keep moving.	• ACTION: **call the office TODAY** — diuretic may need bumping; recheck weight tomorrow.	• ACTION: **911 or ER NOW** — IV diuretics or advanced care may be needed.

Comfort Measures at Home (No Medication Needed)

These simple steps support healing and ease symptoms. Use them alongside any medication your doctor prescribes.

- Weigh yourself daily, same time, same scale, after using the bathroom and before eating. Track it.
- Limit sodium to under 2,000 mg/day. Read every label.
- Limit fluids to 1.5 to 2 liters/day unless told otherwise. Count soup, ice cream, popsicles.
- Walk daily as tolerated. Build up to 30 minutes most days. Cardiac rehab is the safest start.
- Elevate legs when sitting to reduce swelling.
- Get flu and pneumonia shots. Infections trigger HF flares.
- Treat sleep apnea with CPAP if you have it.
- Quit smoking. Avoid alcohol — it weakens heart muscle directly.
- Carry a list of all your medicines. Show it to every dentist, surgeon, and ER doctor.

Risks, Benefits, and Alternatives

Every choice has trade-offs. Use this table to start the shared decision conversation.

Option	Risks	Benefits	Alternatives
4-pillar GDMT	Low BP, kidney changes, high potassium, genital yeast. Most tolerate well with lab checks.	Cuts CV death by 60 to 70%. Cuts HF hospital stays in half. Many patients see EF rise 10 to 20 points.	ACEi or ARB if ARNI fails. Vericiguat for select patients.
ICD	Small implant risk. Wrong shock in about 5%. Can cause anxiety in some patients.	23% lower mortality when EF stays at or below 35% (SCD-HeFT). Stops sudden cardiac death.	WCD vest for the first 90 days. Watchful waiting if EF rises above 35%.
CRT-D	Same as ICD plus a third lead. Not every patient responds.	Best when QRS is wide (150 ms or more) with LBBB. Many feel more energetic within weeks (CARE-HF).	ICD alone if no LBBB. His or LBB-area pacing is a newer option.
LVAD or heart transplant	Major surgery. Lifelong immune suppression for transplant. Stroke risk with LVAD.	For stage D HFrEF only. Adds years of life when medicines and devices are not enough.	Inotropes at home, hospice, or staying on GDMT alone.
Diuretic only (no GDMT)	Fluid relief only. Does not treat the disease. Risk of dehydration and low sodium.	Fast relief of congestion. Cheap.	Modern care adds the 4 pillars. Diuretic alone is for hospice.

Common Misconceptions

Myth	Reality
HFrEF is a death sentence.	Modern 4-pillar therapy has cut 5-year death rates a lot. Many patients live decades after diagnosis.
I should rest as much as possible.	Cardiac rehab and steady aerobic exercise are real treatment. Movement helps the failing heart.
My EF improved — I can stop my medicines.	You feel better BECAUSE the medicines are working. Stopping leads to a fast rebound and hospital stay, even when EF is normal.
Drinking more water flushes the heart.	HFrEF means too much fluid, not too little. Most patients limit fluids to about 2 liters a day.
Salt is fine if my blood pressure is normal.	Salt drives fluid build-up apart from blood pressure. Aim under 2 grams sodium a day.
An ICD is only for older people.	ICDs are advised for any patient with EF 35% or lower and a meaningful life expectancy, at any age.
Beta-blockers are dangerous in heart failure.	The opposite is true. Beta-blockers shield the failing heart from stress hormones and cut death by about 34%.
If my heart attack was small, I cannot get HFrEF.	Even small or silent heart attacks can damage muscle and lower EF. Get follow-up echocardiograms.

Possible Complications

Knowing what can go wrong helps you spot problems early. Most complications are uncommon, especially with treatment.

Where / What	What Can Happen
Acute decompensation	Sudden fluid build-up. Often triggered by salt, missed pills, or infection. Catch it early with daily weights.
Sudden cardiac death	From VT or VF. The biggest danger of untreated HFrEF. An ICD stops this when EF stays at or below 35%.
Atrial fibrillation	Up to 30% of HFrEF patients get AFib. Raises stroke risk. A blood thinner is usually added.
Kidney dysfunction	Heart and kidneys share the same plumbing. SGLT2 inhibitors and careful diuretic dosing help.
Muscle wasting (cachexia)	Advanced HFrEF can cause weight loss. Nutrition support and cardiac rehab slow this.
Liver congestion	Late finding. Belly swelling and poor appetite. Diuretics help.
Depression and anxiety	Affects about 1 in 3 patients. Treatment helps. Tell us.
Stroke	From AFib, low output, or LV clot. A blood thinner is often added. Call 911 for any stroke symptom.

Cardiac rehab matters. A 12-week program of supervised exercise plus coaching cuts death and hospital stays by about 25%. Medicare covers it after a HF event. Ask us to refer you.

Points to Know

If you remember nothing else, remember these key points.

- Weigh yourself daily, same time, same scale. Tell us if you gain more than 3 lb in a day or 5 lb in a week.
- Sodium under 2,000 mg/day. Read every label.
- Take all 4 GDMT pillars if prescribed: ARNI (or ACEi/ARB), beta-blocker, MRA, SGLT2 inhibitor. Each one matters.
- Get every vaccine on schedule. Flu and pneumonia trigger HF flares.
- Cardiac rehab is treatment, not optional. Say yes if it is offered.
- Never stop a heart-failure medicine on your own.
- Most heart attacks are silent in HFrEF — stick with statin and blood-pressure control even if you feel fine.
- EF can rise with treatment. Recheck echo at 3 to 6 months after starting GDMT.
- If you have an ICD, the device guards against sudden death. If you get a shock, call us the same day; call 911 for repeated shocks.
- Tell every dentist, surgeon, and ER doctor about your HFrEF and your medicine list before any procedure.

Heart failure to heart success. HFrEF used to be a diagnosis with few options. Today, with the 4 pillars, devices when needed, rehab, and good self-care, many patients live longer, hospitalize less, and feel better. The diagnosis is the starting point — not the destination.

When to Call Us - and When to Call 911

If you are not sure, call. We would rather hear from you twice than miss a real problem.

- Weight gain more than 3 lb in 2 days or 5 lb in a week.
- New or worse shortness of breath, especially when lying flat.
- Need more pillows than usual to breathe at night, or waking gasping for breath.
- New or worse leg, ankle, or belly swelling.
- Dizziness, lightheadedness, or near-fainting.
- Chest pain or pressure — call 911.
- ICD shock — single shock, call us the same day; two or more shocks, call 911.
- Stroke signs (face droop, arm weakness, slurred speech) — call 911.
- Coughing up pink or frothy mucus — call 911.
- Fever over 100.4 F that lasts more than 24 hours.
- Any plan to stop a heart medicine — call us first.

Office: (727) 943-5200

Trusted Resources

The links below are the trusted resources Dr. Ali used to write this guide and that he recommends you visit for more information. Each is a clickable link in the digital version and a Short.io tracked URL on the printed version.

- AHA - Heart Failure - Plain-language overview from the American Heart Association.
- Mayo Clinic - Heart Failure - Comprehensive patient overview with FAQs.
- Cleveland Clinic - HFrEF - Diagnosis, treatment, and recovery details.
- NHLBI - Heart Failure - Official NIH HF patient page.
- HFSA Patient Hub - Heart Failure Society of America patient materials.
- Million Hearts - Cardiac Rehab - CDC/CMS resource - why rehab cuts death and hospital stays.

Sources Used to Build This Guide

Every recommendation in this guide is grounded in one or more of the studies, guidelines, or trusted resources below. Short links are tracked so Dr. Ali can see which references patients are reading; nothing personally identifying is captured.

- 2022 AHA/ACC/HFSA Guideline for Heart Failure *[Guideline]*
  Primary HFrEF framework: GDMT, devices, monitoring.
- 2023 ACC Expert Consensus on Heart Failure (GDMT optimization) *[Guideline]*
  SGLT2i is Class I for all HFrEF regardless of diabetes; rapid 4-pillar start.
- PARADIGM-HF (sacubitril/valsartan vs enalapril) *[Clinical Trial]*
  ARNI cut CV death and HF hospitalization by 20% vs ACEi.
- EMPEROR-Reduced (empagliflozin in HFrEF) *[Clinical Trial]*
  SGLT2i reduced CV death + HF hospitalization by 25%.
- DAPA-HF (dapagliflozin in HFrEF) *[Clinical Trial]*
  First SGLT2i HFrEF trial — 26% drop in worsening HF / CV death.
- RALES (spironolactone in severe HFrEF) *[Clinical Trial]*
  MRA reduced mortality by 30% in severe HFrEF.
- MERIT-HF (metoprolol succinate) *[Clinical Trial]*
  Beta-blocker reduced all-cause mortality by 34%.
- SCD-HeFT (ICD in HFrEF) *[Clinical Trial]*
  ICD cut all-cause mortality 23% when EF 35% or lower.
- CARE-HF (CRT in HFrEF + LBBB) *[Clinical Trial]*
  CRT reduced hospitalizations and mortality with LBBB.
- VICTORIA (vericiguat for worsening HFrEF) *[Clinical Trial]*
  Vericiguat lowered CV death / HF hospitalization in recently decompensated HFrEF.
- A-HeFT (hydralazine + isosorbide dinitrate) *[Clinical Trial]*
  Hydralazine/nitrate cut mortality 43% in self-identified Black HFrEF patients.
- AHA — Heart Failure *[Patient Education]*
  Plain-language AHA HF resource.
- NHLBI — Heart Failure *[Patient Education]*
  Official NIH HF patient page.

About This Guide

Rias KS Ali, MD FACC | Board Certified in Interventional Cardiology & Cardiovascular Disease

4740 Mile Stretch Drive, Holiday FL 34690 | Office: (727) 943-5200 | Fax: (727) 943-5201 | RiasAliMD.com

Version: 2026-08-15

Reviewer note: Reviewed against AHA, Mayo Clinic, and Cleveland Clinic HF pages. Ours adds a 4-pillar GDMT diagram with named trial evidence, color-coded NYHA staging, an EF-band visual, a device step-up ladder, and a green-yellow-red daily-weight action plan.

Disclaimer

This guide is for educational purposes only and does not replace medical advice from your physician. Recommendations may not apply to every patient. Always follow the specific instructions of Dr. Ali and your care team. In an emergency call 911 or go to the nearest emergency department.

Take This Guide With You

Scan or visit: https://go.riasalimd.com/hf-guide

Online: https://go.riasalimd.com/hf-guide

Office: (727) 943-5200

4740 Mile Stretch Drive, Holiday FL 34690 | Office: (727) 943-5200 | Fax: (727) 943-5201 | RiasAliMD.com