HeartCare Texas

Cardio Vascular Specialists

___Mr. ___Mrs. ___Miss ___Ms. ___Dr.

Last Name: _____ First: _____ M: _____

Address: _____

City: _____ State: _____ Zip: _____

Best day time phone number: _____

Alternate: _____

Primary Care Provider: _____

Referring provider, if other than PCP: _____

Date of Birth: _____/_____/_____ _____Male _____Female _____ Transgender

Email address: _____

Race: ___American Indian, Alaskan Native ___Asian ____Native Hawaiian, Pacific Islander ___Black/African American ___White ___Hispanic ___Other ___Declined

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Declined

Language: ___English ___Spanish ___ Any other. ___ Is a translator requested at appts.?

Marital Status: _____ Social Security Number: _____

Employer Name: _____ Employment Status: _____

Student: ____Yes, ____Full time ____Part time ____Not a student

Emergency Contact: Last Name: _____ First Name: _____

Phone Number: _____ Relation: _____

____ Do You Have a Living Will?

RESPONSIBLE PARTY

____ Self ____ Guarantor

Patient Name: _____ DOB: _____

LOCAL:

Pharmacy Name: _____

Address: _____

_____

Phone #: _____

MAIL ORDER: _____

Guarantor Name: Last: _____ First: _____

Latex Allergy: _____

MEDICATION PRESCRIPTION POLICY & AGREEMENT:

If you need a refill on your medication, we ask that you call the pharmacy. They will then send a refill request electronically to us. If you do call us, we will ask you to call the pharmacy.

We do not refill medication after hours or on weekends. Our providers do not have access to your records when they are away from the office. Please call the pharmacy at least 3 days before you need the medication. Our providers need time to process the requests.

Any refills sent to us after the 3:30 PM will be processed the next business day.

OFFICE HOURS:

We will be open Monday thru Friday between the hours of 8:00 AM & 5:00 PM. We do not close for lunch.

As always, if you feel you are in an emergent situation, hang up & dial 911.

FINANCIAL AGREEMENT:

*I acknowledge that HeartCare Texas may bill my insurance company for services provided to me.

*I agree to pay for services that are not covered or covered charges that are not paid in full by the insurance company. These charges can include any co-pays, co-insurance, and/or deductibles.

*I acknowledge that HeartCare Texas may use the services of a third-party business associate or affiliated entity as an extended business office for medical account billing and servicing.

*I hereby assign to HeartCare Texas any insurance or other third-party benefits available for health care services provided to me. I understand HeartCare Texas has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to HeartCare Texas, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

*Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to HeartCare Texas by the Medicare or Medicaid program.

*Consent to telephone calls for financial communications. I agree that, in order for HeartCare Texas or extended business office (EBO) servicers & collection agents, to service my

account or to collect any amounts I may owe. I expressly agree and consent that Heartcare Texas or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or HeartCare Texas or EBO servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative: _____ Date: _____

If you are not the patient, please identify your relationship to the patient.

_____

New Patient History:

Patient name: _____ DOB: _____ Date: _____

Describe your main problems:

List any allergies or adverse reactions:

Drug/Allergen:	Reaction:	Onset:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____NKDA (no known allergies)

List all current medications, dosage & reason:

Name:	Dosage:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all providers you are currently seeing:

Name:	Specialty:
_____	_____
_____	_____
_____	_____
_____	_____

Past medical history:

___ Other: _____	___ Anxiety Disorder	___ Aortic Aneurysm
___ ADD or ADHD	___ Arrhythmia	___ Arthritis
___ Allergies	___ Anemia	___ Asthma
___ A Fib	___ Back Pain	___ Bedwetting

___ Birth defect or inherited disease
___ Bleeding disorder
___ Blood Clots
___ Breast cancer
___ CAD
___ COPD
___ Heart Problems
___ Heart Valve Disorder
___ Heart attack
___ Heart Murmur
___ Hemophilia
___ Hepatitis
___ Hernia
___ Hiatal Hernia
___ Hypercholesterolemia
___ Hyperlipidemia
___ Hypertension
___ Hyperthyroidism
___ Hypothyroidism
___ Joint Pain
___ kidney disease
___ Kidney Stones
___ Leg or foot ulcers
___ CVA
___ Cancer
___ Chest Pain
___ Chicken Pox
___ Claustrophobia
___ congenital heart disease
___ Congestive Heart Disease
___ Constipation
___ Depression
___ Development/Behavioral
___ Diabetes
___ Diverticulitis
___ Ear/Hearing problems
___ Eczema, Hives, skin issues
___ Endometriosis
___ Epilepsy
___ Fibromyalgia
___ GERD
___ Gastro Disease
___ Genitourinary Disease
___ Gout
___ HIV or AIDS
___ Head Trauma
___ Headaches or migraines
___ Liver disease
___ Obesity
___ Organ transplant
___ Osteoarthritis
___ Osteopenia
___ Pacemaker
___ Pulmonary Embolism
___ Rheumatoid arthritis
___ Seizures
___ Short of breath
___ Sleep apnea
___ Stroke
___ Thyroid problems
___ Tuberculosis
___ Ulcers
___ UTI
___ Alcohol or drug abuse

Family History:

Family member:	Disease:	Onset:	Died:
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____

Spouse: _____ _____ _____

Children: _____ _____ _____

_____ _____ _____

_____ _____ _____

Other: _____ _____ _____

Surgical History:

Procedure: Surgery Date:

_____ _____

_____ _____

_____ _____

Patient Social History:

Smoking status-select one:

___ Never ___Current everyday smoker ___Former Smoker ___ Current occasional smoker

Smoking how much: _____ pack per day ____ years of use

Occupation: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Separated ___Widowed

___ Domestic Partner

Exercise Level: ___ None ___ Moderate ___ Occasional ___ Heavy

Diet: ___Regular ___ Vegetarian ___ Vegan ___ Gluten Free ___ Specific

___ Carbohydrate ___ Cardiac/Diabetic

General Stress Level: ___ Low ___ Medium ___High

Alcohol Intake: ___ None ___ Occasional ___ Moderate ___ Heavy

___ Years of use

Caffeine Intake: ___ None ___ Moderate ___ Occasional ___ Heavy

Chewing tobacco: ___ None ___ 1/day ___ 2-4/day ___ 5+/day

Illicit drugs:

_____

_____

_____

Passive Smoke exposure: _____

Family History of heart disease?	Yes	No
Family history of heart disease before Late 50's?	Yes	No
At risk for hep B?	Yes	No
At risk for TB?	Yes	No

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian, representative, etc)	Date

Practice OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

HeartCare Texas
Cardiovascular Specialists

MEDICAL RELEASE FORM

Patient's name _____

Date of birth ___/___/___

Social Security Number _____-___-_____

Address

_____

_____

_____

Telephone number (___) ___-_____

Please release my medical records from:

Name of provider _____
Provider's address _____

_____

_____

_____

TO:

Name of provider _____
Provider's address _____

_____

_____

_____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____

Patient's Signature Date