PATIENT REGISTRATION

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____ Gender: _____

Email: _____

Spouse/Partner Name: _____ Phone: _____

EMERGENCY CONTACT (FAMILY OR FRIEND NOT LIVING WITH YOU)

First Name: _____ Last Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

FINANCIAL POLICY

Thank you for choosing the physicians of Texas Heart & Vascular as your health-care providers. We are committed to the success of your medical treatment and well-being. Please understand that payment of your medical bill is part of your treatment and care.

If we participate with your insurance carrier, we will submit a claim for covered services rendered on behalf of Texas Heart & Vascular. However, you will be responsible at the time of service for the payment of your annual deductible, copayments, co-insurance, and charges for any non-covered service. It is your responsibility to notify us of any updates to your insurance coverage; otherwise, you will be responsible for payment in full at the time of service. Our office accepts cash, check, VISA, MasterCard, American Express, and Discover.

We make every effort to help determine your insurance benefits in advance, and we will attempt to apprise you of your out-of-pocket expense, if any, before services are rendered. Ultimately, however, if your insurance plan requires authorization prior to your visit, and we have not received an authorization prior to your appointment, you will be asked to either sign a waiver of medical benefits, reschedule, or pay out-of-pocket for the visit. **All HMOs require a referral and/or authorization from your primary care physician.** If you choose to be seen without a referral, your visit will be considered out-of-network and you will be responsible for paying those fees.

Patients without health insurance are eligible for a 35% uninsured discount per qualifying visit. This discount is limited only to patients who have no Third Party Payer source and cannot be applied to insurance deductible, coinsurance, or co-pay. For diagnostic testing (excluding St. David's Cardiovascular Imaging Center) and for patients without health insurance, one-third of the full amount is expected at the time of service, with the remaining balance divided into monthly installments. If the remaining balance exceeds
$500, you will be required to pay your balance in full in no more than six (6) monthly installments. If the amount you owe is less than $500, you will be required to pay your balance in full in no more than four (4) monthly installments. Payment plans must be arranged prior to your visit by contacting our insurance department at 623-5300, option 5. If a payment plan is arranged prior to your visit, the first payment will be due at the time of service.

If the patient finalizes a payment arrangement within 45 days of receiving the first statement, then no adverse information will be submitted to consumer reporting agencies. In the event that we receive a returned check, a fee of $35 will be charged to your account, and payment in full is due upon receipt of your statement.

TEXAS HEART & VASCULAR

All questions regarding charges incurred should be directed to our billing department at 877-943-2823.

Your signature below signifies that you understand the above-stated financial policy and your responsibility regarding charges incurred by this office.

In addition, I verify that the insurance cards presented today are a true, accurate, and complete representation of my personal medical insurance coverage. I verify that I have no other health insurance coverage other than those provided. I authorize Texas Heart & Vascular, PA, to apply for benefits on my behalf for covered services rendered either by professional or professional order, and request that payment is made directly to the professional association. I authorize the release of any medical information necessary to process claims. I understand that I am responsible for payment of any insurance deductible, coinsurance, copayment and/or services that are not covered due to contractual limitations. I permit a copy of this authorization to be used in place of the original.

Please note that most charges pertain to services which are requested outside an office visit. Fee(s) must be paid prior to processing requests. Please note that the list of service fees is subject to change.

SERVICE DESCRIPTION	CHARGE
Clearance to Exercise Form/Letter (outside a routine office visit) Return to Work Releases (outside a routine office visit) Authorizing Handicap placards from DPS (outside a routine office visit) Travel Plan Changes due to Illness Letters Permission to Travel Letter Patient Medication Assistance Forms Review of Extensive Blood Pressure Logs (outside a routine office visit) FMLA Forms Letters for Insurance Companies Disability Forms FAA Flight Physical Forms Jury Duty Letters Medical (including Dental) Clearance Forms/Letters Surgical Clearance Forms/Letters Request for Medical Records	$25.00

Please note that completion of these forms may take 7 to 10 business days. An additional $10.00 fee will be added to your balance due at the time of your request if you would like your document completed in less than 3 to 7 business days.

I have received, read and understand the Texas Heart & Vascular Financial Policy and the policy regarding Charges for Patient Services Not Typically Covered by Insurance.

_____ _____

Patient Signature **Date**

_____ _____

Staff Signature **Date**

4316 James Casey, Bldg. A & C Austin, Texas 78745
Telephone: (512) 623-5300 Fax: (512) 623-5399
www.THandV.com

TEXAS HEART & VASCULAR

TH&V REVIEW OF SYSTEMS PROGRESS NOTE

DATE: _____

PATIENT NAME: _____ **DOB:** _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

PHARMACY NAME: _____ **PHARMACY ADDRESS:** _____

PREFERRED LANGUAGE: _____ **RACE:** _____

ETHNICITY (CIRCLE ONE): HISPANIC OR LATINO NON-HISPANIC OR LATINO OTHER OR UNDETERMINED

Please check as many of the following **NEW** symptoms that you have experienced

- ☐ Anxiety
- ☐ Asthma
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Chest heaviness
- ☐ Chest pain
- ☐ Chest tightness
- ☐ Cough
- ☐ Depression
- ☐ Dizziness
- ☐ Edema/leg swelling
- ☐ Fatigue/weakness
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Joint pain
- ☐ Leg pain with walking/exercising
- ☐ Lightheadedness
- ☐ Muscle pain or weakness
- ☐ Numbness/tingling in extremities
- ☐ Pain between shoulder blades/ jaw/arms with exertion or exercise
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Shortness of breath while lying down
- ☐ Significant weight change
- ☐ Skin rash
- ☐ Sleep disorder/apnea
- ☐ Stomach pain after eating

☐ **DENY ALL OF THE ABOVE (if nothing has changed since your last visit, please mark this box)**

LAST FLU VACCINE (Month: _____ Year: _____)

LAST PNEUMONIA VACCINE (only if age 65 or older) (Month: _____ Year: _____)

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? YES _____ NO _____

If "yes" and you are 65 or older please provide the following: Name _____ Phone Number _____

SINCE YOUR LAST VISIT have you had any of the following?

Please check "Yes" or "No" and provide details in the space provided.

	Yes	No	
New medication allergies?	☐	☐	If yes, please list: _____
Hospitalizations?	☐	☐	**When & why:** _____
New illness or diagnosis?	☐	☐	Name of illness/diagnosis: _____
New lab or diagnostic test?	☐	☐	Name of lab/test: _____
Change in Social history?	☐	☐	Explain: _____
Do you smoke?	☐	☐	Packs per day: _____ Years? _____
Do you drink alcohol?	☐	☐	Amount per day: _____ Type? _____
Caffeine use?	☐	☐	Amount per day: _____
Drug use?	☐	☐	If yes, what type of substance? _____
Exercise?	☐	☐	Times per week: _____ Type: _____
Change in family history?	☐	☐	Explain: _____

_____ _____

Patient Signature **Date**

For Office Use Only	Pulse/Rhythm	Respirations	Weight/BMI	Temp	HT	Notes
MA Initials:	Blood Pressure	Supine	Sitting	Standing		
	Right Arm					
	Left Arm					

TEXAS HEART & VASCULAR
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MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME:_____**DATE:**_____**DOB:**_____

FAMILY MEDICAL HISTORY:

	Father	Mother	Sister 1	Sister 2	Brother 1	Brother 2
Diabetes						
Heart Attack (Age <65)						
High Blood Pressure						
Living						
Stroke/CVA (Age <65)						

ALLERGIES:

	Yes	No
Are you allergic to iodine or shellfish?	☐	☐
Have you had a reaction to x-ray contrast dye?	☐	☐
Are you allergic to any medications?	☐	☐

(If yes, please list medication names): _____

PAST MEDICAL HISTORY:

☐Abnormal Heart Rhythm	☐Cancer	☐High Blood Pressure	☐Sleep Apnea
☐Anemia or Blood Disorder	☐COPD/Emphysema	☐High Cholesterol	☐Stroke or TIA
☐Anxiety	☐Diabetes	☐High Triglycerides	☐Thyroid Disorder
☐Asthma	☐Easy bruising/bleeding	☐HIV/AIDS	☐Tuberculosis
☐Arthritis	☐Heart Attack	☐Kidney Disorder	☐Valvular Heart Disease
☐Atrial Fibrillation	☐Heart Murmur	☐Liver Problems	☐Varicose Veins
☐Blood Clots veins/lungs	☐Hepatitis	☐Seizures	

NON-CARDIAC PAST SURGICAL HISTORY:

_____

_____

CARDIOVASCULAR TESTING & SURGICAL HISTORY:

☐Cardiac Echocardiogram	☐Electrophysiology Study	☐Coronary Angioplasty (balloon)/Stents
☐Nuclear Testing	☐Pacemaker/ICD	☐Valve repair or replacement
☐Vascular Testing	☐Bypass Surgery	☐Stress Test
☐Holter Monitor or Event Monitor	☐Heart Catheterization	☐Heart Transplant

SOCIAL HISTORY:

TOBACCO USE: Currently smoke? _____packs per day for _____years
Previous smoker for _____years. Date/Year quit:_____

ALCOHOL USE: ☐Yes ☐No If yes, how many drinks per day? _____

CAFFEINE: ☐Yes ☐No If yes, how many caffeinated drinks per day? _____

DRUG USE: Have you ever used illicit drugs? Yes☐ ☐No If yes, year started/stopped?_____

PARTICULAR DIET: ☐Yes ☐No If so, please describe_____

EXERCISE: ☐Yes ☐No If yes, what type?_____ How often?_____

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PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

Today's Date: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice 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 practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice 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 admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. 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.

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

Updated: June 12, 2015, replacing November 21, 2013 version

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility 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 without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

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.
____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:
Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date: _____

Patient Name (Printed): _____ DOB: _____

Updated: June 12, 2015, replacing November 21, 2013 version

PATIENT NAME_____ **DATE OF BIRTH**_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ **(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, Texas Heart & Vascular may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____ **(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that Texas Heart & Vascular may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ **(Patient or Guardian Initials)**

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

4. _____ **(Patient or Guardian Initials)**

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 Texas Heart & Vascular by the Medicare or Medicaid program.

5. _____ **(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for Texas Heart & Vascular, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Texas Heart & Vascular or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Texas Heart & Vascular 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 pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ **(Patient or Guardian Initials)**

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

Patient/Patient Representative Signature:

X_____ Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

TEXAS HEART & VASCULAR

MEDICAL RECORDS RELEASE

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Address: _____

Phone: _____ Cardiologist: _____

RECORD TO BE RELEASED FROM

Physician Name/Clinic: _____ Phone: _____

Address: _____ Fax: _____

RECORD TO BE RELEASE TO

Name: **Texas Heart & Vascular** Phone: **512-623-5300**

Address: **4316 James Casey St. Bldg A & C Austin TX 78745** Fax: **512-904-1702**

RELEASE THE FOLLOWING

- ☐ Cath/Op Reports
- ☐ Echo Reports
- ☐ EKG
- ☐ Entire Chart
- ☐ Lab Reports
- ☐ Progress Note
- ☐ Treadmill Results
- ☐ X-rays
- ☐ Other:

PURPOSE OF DISCLOSURE

- ☐ Attending Physician Statement
- ☐ Consultation
- ☐ Disability
- ☐ Further Medical Care
- ☐ Legal Investigation
- ☐ Payment of Claim
- ☐ Personal
- ☐ Research Participation
- ☐ Other:

I hereby authorize the release of my medical records, including all results and tests that may include the following data: drug, alcohol, and psychiatric treatment to the party noted above.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
I understand that I do not have to sign this authorization and my treatment or payments for services will not be denied if I do not sign this form unless specified above under Purpose of Disclosure.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will expire ninety (365) days from the date of my signature or as otherwise specified by date, event, or conditions as follows:

Patient Signature: _____ Date: _____

Witness: _____ Date: _____