

Patient Registration Form

Phone : (214) 884-7525 , Fax : (214) 884-7551

Patient Information					
Last Name		First Name		Middle Initial	
Date of Birth	Social Security Number		Gender		
Street Address		Apt.	City	State	Zip
Patient Employer			Work Number		
Home Phone		Cell Phone or Other			
Emergency Contact Name		Emergency Contact Number		Relationship	
Referring Provider (This section MUST be completed for Insurance Purposes)					
Physician's Name			Phone Number		
Insurance Information					
Primary Insurance		Insurance Phone	Subscriber Name	Relationship	
ID Number	Group Number		Subscriber SS#	Date of Birth	
Address of Insurance (Street or P.O. Box, City, State Zip)					
Secondary Insurance		Insurance Phone	Subscriber Name	Relationship	
ID Number	Group Number		Subscriber SS#	Date of Birth	
Pharmacy Name, address & Telephone Number:					

Consent For E-Prescribing & Medication History: I Understand that as a part of my electronic health record, Precision Cardiac and Vascular Care will transmit my prescription electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, Precision and Cardiac and Vascular Care will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit manager and I understand that those prescriptions will become a part of my electronic record. By signing below I hereby give consent to the above actions.

Signature of Patient _____ Date _____

I hereby authorize Precision Cardiac and Vascular Care to perform medical services and bill my insurance company for services and the release of these reports requested by my physician or insurance company and/or to their designate(s) when necessary to process the claim for clinical review. Precision Cardiac and Vascular Care will send the claim to the listed insurance carriers as a courtesy. The policy holder or subscriber is responsible for understanding the parameters of their insurance (i.e.: In-network, out-of-network, deductibles, co-pays and if a pre-authorization is needed for ordered tests. If, for any reason, your insurance company does not cover any performed services, the subscriber is responsible for payment of outstanding balances. **Thank You!**

Signature of Patient _____ Date _____

**Authorization Form For
Release of Protected Health Information**

By signing this form, I authorize you to use and disclose the protected health information described below to family members or other persons of my choosing as designated on the document.

Patient Name: ----- **Date of Birth:** -----

My PREFERRED Method of Contact is:

(Check one that is PREFERRED & provide all additional contact information below)

Telephone (Cell/Home/Work) My number is: _____ Text

Message. My number is:

E-Mail. My e-mail address is: _____

Check all that apply below:

It is O.K. to leave me a message with detailed information. It is NOT O.K.

It is O.K. to contact me at work. My number is: _____

It is O.K. to leave me a message at work with detailed information.

It is NOT O.K. to leave me a message at work with detailed information

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

My spouse, whose name is: _____ Phone: My parent, _____ whose name is: _____ Phone: My child, whose name is: ----- _____ Phone:

No one other than myself _____

Fill in any other name you desire: _____

Signature of Patient or Personal Representative

Date

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient

Signature of Patient or Responsible Party if a Minor

Date

Patient Agreement in Office Policies

"Our financial policy has been set up to prevent misunderstandings"

- I hereby agree to assign payments over to the office of Precision Cardiac and Vascular Care if my insurance carrier does not cover services, due to co-payments, deductible, co-insurance etc
- I realize that I am responsible for payment for any or of any treatments that my insurance carrier may not pay.
- **I am responsible for my \$ deductible and co-payment which has been determined by my insurance. My co-payment and deductible will be paid at the time of the service, unless other arrangements have been made with the office. If insurance information is incorrect, I will be responsible for entire payment.**
- I understand that a \$20.00 fee will be charged for all returned/bad checks and will terminate my privilege to pay by check on future visits.
- I understand and agree that in the event of any outstanding balance has to referred to a collection agency or attorney for recovery, I will be responsible for all collection and attorney's fees.
- Because your time is valuable, we will make every effort to being promptly. However, our time is equally as important and we expect that you be on time for scheduled appointments and give us 24 hours notice of any cancellation.

Please sign below to indicate that you have read and fully understand the policy.

Signature

Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Patient Information Sheet

Patient Name: _____

Date : _____

DOB : _____

Sex : _____

Age : _____

Referring Physician : _____

Reason for Visit : _____

Any Heart / Circulation Problems : Check all that apply :

___ Heat Attack

___ Congestive Heart Failure

___ Defibrillator (ICD)

___ Angioplasty/Stent

___ Arrhythmias / Irregular Heart Beat

___ Heart Valve Surgery

___ Bypass Surgery

___ Varicose Veins (Enlarged Leg Veins)

___ Heart Valve Disorder

___ Heart Murmur

___ Congenital Heart Disease

___ Arterial Fibrillation

___ Cardiomyopathy

___ PAD (Leg Artery Blockage)

___ Mitral Valve Prolapse

___ Pacemaker

___ Heart Cath / Angiogram

Pl. list any other heart conditions: _____ **Other**

Medical Problem : Check all that apply :

___ Asthma

___ Pulmonary Embolism (Clot in Lungs)

___ Stomach Ulcer

___ Cirrhosis

___ PAD (Blockage in Leg Arteries)

___ High Blood Pressure

___ Anemia

___ Emphysema/COPD

___ Stroke /TIA

___ Diabetes

___ DVT (Leg Vein Clot)

___ Enlarged Prostate

___ Arthritis

___ High Cholesterol

___ Kidney Failure

___ Cancer

___ Thyroid Disorder

List Any Previous Operations or other medical problems : _____

Check all that apply :

Current Smoker _____

Smoked in the past _____

Alcohol Use _____

Illicit Drug Use _____

Family History of :

Father

Mother

Other

Sister

Heart Disease

High Blood Pressure

Diabetes

Peripheral Arterial Disease (PAD) Questionnaire

Peripheral Arterial Disease (PAD) is a condition in which the arteries that carry blood to the muscles of the legs become narrowed and hardened due to the buildup of plaque. It can result in leg pain or "fatigue," which can limit your physical activity. PAD can also increase your risk of having a heart attack or stroke if untreated.

- | | | | |
|---|-------|-----|----|
| 1. Do you have any discomfort in the muscles of your legs when you walk that is relieved by rest ? | ----- | YES | NO |
| 2. Do your legs every feel fatigued or heavy when walking or being active ? | ----- | YES | |
| NO | | | |
| 3. Do you ever need to stop and rest when walking or have difficulty keeping up with others ? | ----- | YES | NO |
| 4. Do your feet and toes bother you at night ? | ----- | YES | NO |
| 5. Would you have difficulty doing any of the following because of leg fatigue, weakness, or discomfort ? | ----- | YES | NO |

	No Difficulty	Some Difficulty	
Unable Walking one block	1	2	
3 Climbing One flight of stairs ?	1	2	3
Walking at an increased pace ?	1	2	3

Venous Questionnaire

Disease of leg veins, such as varicose veins (Large bulging veins) or venous insufficiency (leaky leg veins) can cause pain, swelling, infections, and ulcers. These can be frequently treated by ablation or laser treatment. **PI check if you have any of the following symptoms:**

- Leg pain, aching, cramping : _____
- Burning or itching in the legs : _____
- "Heavy" feeling in legs : _____
- Leg swelling, especially towards end of the day : _____
- Varicose Veins : _____
- Skin discoloration or texture changes in legs : _____
- Open wounds or sores in legs : _____

Physician Notes :

Patient Name : _____

Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other patients.

Office appointments which are cancelled with less than 24 hours notification do not receive penalties. However for **ANY** procedure cancellations and or reschedules there is a \$50 Deposit required in order to reschedule the procedure a **third** time. We allow **one** courtesy reschedule for our patients since we are aware unforeseen circumstances can arise. After using the courtesy reschedule we are subject to collect the deposit before placing a future appointment on our schedule.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before being rescheduled. After continued reschedules and or no shows, we are not able to provide that service without collecting the full amount of the procedure.

Our practice firmly believes that good physician/patient relationship is based upon understanding a good communication.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

Patient Name (Please Print)

Date of Birth

Signature of Patient or Patient Representative

Date

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Social Security #: _____ (optional) I authorize

the following individual or organization to disclose the above named individual's health information:

_____ Address: _____

this information may be disclosed to and used by the following individual or organization.

Address: _____ Precision Cardiac and Vascular Care 221 Regency
Parkway, Suite 105, Mansfield, TX 76063

for the purpose

of: _____ Continuity of Care

Please release the following:

- Problem List
- Progress Notes
- History/Physical Exam
- Medication List
- Immunization Record
- List of Allergies
- X All Records
- X-ray/Imaging Reports - from (date) _____ to (date) _____
- X-ray films
- Laboratory Results - from (date) _____ to (date) _____
- EKG Reports
- Genetic Testing Information
- Other Diagnosis Reports (Specify) _____
- Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

- Yes, I consent to the release of this information.
- no, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____ (insert privacy officer or other office or individuals name or contact information).

Signature of Patient or Legal Representative _____ Date _____

Relationship to Patient (If Legal Representative) _____ Date _____

complete only if information is to be released directly to Patient:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative _____ Date _____

Relationship to Patient (If Legal Representative) _____ Witness _____

Date request completed: _____ # of pages copied _____ Reviewed only _____

Charges:\$ _____ Cash: _____ Check #: _____ Initials: _____