

HOUSTON CARDIOVASCULAR ASSOCIATES

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Hello and welcome to Houston Cardiovascular Associates!

Please fill out these forms completely and return them to us as soon as possible, as this will expedite your waiting time on the day of your appointment. This will also help us to verify your insurance information and assist your physician in assessing your cardiac condition.

You may return your completed forms by mail or via fax at 713-790-9663

If you have any questions, please feel free to contact us at 713-790-0841

Thank you

Houston Cardiovascular Associates

HOUSTON CARDIOVASCULAR ASSOCIATES

PATIENT INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____
SS# _____ Sex: M / F / Undiff Date of Birth: _____ Marital Status: M D S W
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Email: _____
Employer's Address _____
Work Status: ☐ Full Time ☐ Part Time ☐ Retired: Date _____ Student Status: ☐ Full Time ☐ Part Time
Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ White ☐ Other Race _____ Preferred choice of Communication Method
Primary/Secondary Language: _____ Email: _____
Preferred Language: _____ Phone: _____
Mail: _____

REFERRING DOCTOR: _____

SPOUSE/GUARDIAN INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____
SS# _____ Sex: M / F / Undiff Date of Birth: _____ Marital Status: M D S W
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Email: _____
Employer's Address _____
Work Status: ☐ Full Time ☐ Part Time ☐ Retired: Date _____ Student Status: ☐ Full Time ☐ Part Time

INSURANCE INFORMATION:

PRIMARY INS: _____ POLICY HOLDER: _____
SECONDARY INS: _____ POLICY HOLDER: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____
Home Phone: _____ Other Phone: _____

PAYMENT POLICY:

Houston Cardiovascular Associates will file a claim in your behalf to your insurance company. The patient's anticipated portion (including co-pay, deductible and/or percentage) is the only amount due today. Preferred method of payment:

☐ CASH

☐ CHECK

☐ CREDIT CARD

Authorization to release information & assignment of benefits:

I hereby authorize payment directly to Houston Cardiovascular Associates for benefits otherwise payable for medical/professional services rendered to me. Furthermore I authorize the release of information acquired in the course of my examination or treatment which is necessary to process an insurance claim. Houston Cardiovascular Associates is authorized to inquire as to the status of insurance claim(s) which have been filed on my behalf. A copy of this authorization is as valid as the original which remains effective one (1) year from the date signed.

I understand that I, the patient/guardian, remain liable for all charges incurred by me, regardless of any insurance coverage, and any problems with the insurance carrier are between the insured and the insurance company.

Signature _____

Date _____

Houston Cardiovascular Associates

Receipt of Notice of Privacy Practices Written Acknowledgment Form / Authorization to Release Protected Health Information to Personal Representatives

In compliance with the Health Information Portability and Accountability Act (HIPAA) and because it is our sincere desire to protect your right to privacy, we are implementing a policy requiring your written authorization before allowing us to disclose or discuss your personal information with any personal representative effective April 15, 2003. To further protect your right to privacy, we are also required by HIPAA to acquire written acknowledgement that you have received our Notice of Privacy practices.

If you have any questions regarding this form or policy, you may direct them to our HIPAA Coordinator, Jennifer Webb, at 713-790-0841 extension 541.

I, (Patient Name) _____, acknowledge and agree that I have received a copy of Houston Cardiovascular Associates' Notice of Privacy Practices.

I hereby authorize Houston Cardiovascular Associates to disclose information about my account, evaluation and/or treatment to:

EXAMPLE:

	<u>JANE DOE</u>	<u>SPOUSE</u>	<u>(713) 555-5555</u>
	Name	Relationship	Phone
1)	_____	_____	_____
	Name	Relationship	Phone
2)	_____	_____	_____
	Name	Relationship	Phone
3)	_____	_____	_____
	Name	Relationship	Phone

SIGNED: _____ DATE: _____

This consent is subject to written revocation by the above signed at any time except to the extent that action has been taken. I hereby release the aforementioned facility from any/all legal liability that may arise from the release of this information to the party named above. A copy or fax of this authorization is as valid as the original.

MEDICAL HISTORY

DATE: _____

NAME _____ BIRTH DATE _____ AGE _____
(LAST) (FIRST) (MIDDLE INITIAL)

SPOUSE NAME _____ BIRTH DATE _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER HOME: _____ WORK: _____
(AREA CODE) (AREA CODE)

SOCIAL SECURITY # _____

REFERRING PHYSICIAN _____
ADDRESS INCLUDING CITY AND STATE, ZIP _____

WHO IS FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE? _____

PROBLEMS: (State reasons you want to see a doctor. List in order of importance to you.) You may use last page to describe in detail if you wish.

1. _____
2. _____
3. _____
4. _____

LIST OTHER PHYSICIANS SEEN IN LAST TWO YEARS AND WHY. _____

PAST MEDICAL HISTORY

1. Illnesses (requiring hospitalization, list problem and year, do not list operation here)

- | | |
|-----------|-----------|
| (a) _____ | (d) _____ |
| (b) _____ | (e) _____ |
| (c) _____ | (f) _____ |

2. Accidents (list broken bones, injuries, etc.)

- | | |
|-----------|-----------|
| (a) _____ | (d) _____ |
| (b) _____ | (e) _____ |
| (c) _____ | (f) _____ |

3. Operations (list all and give year)

- | | |
|-----------|-----------|
| (a) _____ | (d) _____ |
| (b) _____ | (e) _____ |
| (c) _____ | (f) _____ |

4. Allergies (have you had reactions to any of the following medications (yes or no) and describe the reaction; for example, "Rash, asthma, hives, blackout")

- | | |
|----------------------|------------------------|
| (a) Penicillin _____ | (e) Demerol _____ |
| (b) Sulfa _____ | (f) Barbiturates _____ |
| (c) Aspirin _____ | (g) Anesthetics _____ |
| (d) Codeine _____ | (h) Other _____ |

5. Pregnancies _____ Miscarriages _____ Weight of largest child at birth _____

6. Medications (list all you are now taking or have taken [in the past month] and indicate how often you have taken them): BRING ALL MEDICATIONS WITH YOU.

- | | | |
|-----------|-----------|------------------------------|
| (a) _____ | (e) _____ | (i) How much aspirin _____ |
| (b) _____ | (f) _____ | (j) Laxatives _____ |
| (c) _____ | (g) _____ | (k) Oral contraceptive _____ |
| (d) _____ | (h) _____ | (l) Sleeping pills _____ |

MEDICAL HISTORY (continued)

FAMILY HISTORY	Age	State of Health	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
(circle one) M F	_____	_____	_____
M F	_____	_____	_____
M F	_____	_____	_____
M F	_____	_____	_____

FAMILY HISTORY (continued)	Father	Mother	Sister(s)	Brother(s)	Other
1. Goiter					
2. Cancer					
3. Tuberculosis					
4. Allergies or asthma					
5. Strokes					
6. Nervous breakdown					
7. Suicide					
8. Convulsions/epilepsy					
9. Headaches					
10. Diabetes					
11. Arthritis					
12. Heart attack					
13. High blood pressure					
14. Gout					
15. Kidney stone					
16. Bleeding problem					
17. Ulcers					
18. Stroke or heart attack prior to age 60					

MEDICAL HISTORY (Continued)

REVIEW OF SYSTEMS: Review the list below and CIRCLE any number that describes a problem you are currently having and UNDERLINE those problems you have frequently had in the past.

- | | | |
|--|--|--|
| 1. Headaches | 37. Constipation, chronic | 69. Back pain—high |
| 2. Seizures or fits | 38. Vomit blood | 70. Back pain—low |
| 3. Numbness or tingling in hands, feet, arms or legs | 39. Have blood with bowel movements | 71. Change in glove size, shoe size or hat size |
| 4. Weakness in hands, feet, arms or legs | 40. Black, loose bowel movements | 72. Muscle cramps in arms, legs, hands or feet |
| 5. Difficulty maintaining balance | 41. Stomach pain | 73. Pain in legs while walking |
| 6. Dizziness | 42. Jaundice (yellow skin) | 74. Joint swelling |
| 7. Fainting or blackout spells | 43. Stomach ulcers | 75. Joint pain |
| 8. Strokes | 44. Hemorrhoids | 76. Pain in hands or feet on cold weather exposure |
| 9. Ringing in ears | 45. Weight loss | 77. Skin rash |
| 10. Difficulty with hearing | 46. Weight gain in past year | 78. Dry skin |
| 11. Difficulty with vision | 47. Loss of appetite | 79. Increase in hair growth |
| 12. Double vision | 48. Frequent urination or passing water | 80. Loss of hair |
| 13. Difficulty smelling things | 49. Urination at night | 81. Increase in oiliness of skin |
| 14. Excessive sneezing | 50. Pain on urination | 82. Hives |
| 15. Trouble breathing through nose | 51. Pus or milky color of urine (water) | 83. Excessive sweating |
| 16. Nose bleeds | 52. Blood in urine | 84. Prefer hot water |
| 17. Change in voice | 53. Pass a stone in urine | 85. Prefer cold water |
| 18. Shortness of breath at night | 54. Reduction in force or size of urine | 86. Itching of skin |
| 19. Shortness of breath while walking | 55. Difficulty starting urine stream | 87. Skin pallor (paleness) |
| 20. Swelling of ankles or feet | 56. Leakage of urine | 88. Breast discharge |
| 21. Palpitations | 57. Difficulty with erection | 89. Lumps in breast |
| 22. Chest pain or tightness in chest | 58. Difficulty with ejaculation | 90. Painful breast |
| 23. Heart attacks | 59. Discharge from penis | 91. Excessive blistering after sun exposure |
| 24. High cholesterol | 60. Onset of menstruation (age) _____ | 92. Change in facial appearance |
| 25. Swelling of legs | 61. Duration of menstruation in days _____ | 93. Easy bruising |
| 26. Cough | 62. Length of interval between periods _____ | 94. Excessive bleeding after cutting skin |
| 27. Cough up blood | 63. Bleeding between periods | 95. Crying spells |
| 28. Wheezing during breathing | 64. Painful periods | 96. Insomnia |
| 29. Sugar diabetes | 65. Irregular periods | 97. Mood swings |
| 30. High blood pressure | 66. Last menstrual period _____ | 98. Nervousness |
| 31. Night sweats | 67. Last pelvic _____ | 99. Difficulty with memory |
| 32. Continuous fever for greater than 5 days | 68. Vaginal discharge | 100. Problem with thinking clearly |
| 33. Nausea, chronic | | 101. Chronic fatigue or weakness |
| 34. Trouble with swallowing | | 102. Depression and anxiety |
| 35. Vomiting | | |
| 36. Diarrhea, chronic | | |

Weight Age 20 _____ Weight 1 year ago _____ Weight now _____

MEDICAL HISTORY (Continued)

PERSONAL HISTORY

1. Occupation: Yours _____ Spouse's _____
2. Place of employment: _____
3. Education: (circle level completed)
- | High School | College | Masters | Ph.D. | Others |
|-------------|---------|---------|-------|--------|
| 9 10 11 12 | 1 2 3 4 | | | |
4. Marital status: (circle) Single Married Widowed Separated Divorced
5. Religious preference: _____
6. Hobbies: (list) _____
7. Smoking history: Packs each day? _____ For how many years? _____
8. Drinking history: Ounces each day? _____ For how long in years? _____
9. List the individuals that live in your home: _____

10. Whom should we contact in the event you develop a medical emergency (give name, address, phone number and relation to you)

11. How much exercise do you get (walking, jogging, bicycling, swimming, golf, tennis, other: circle please).
Min each day? _____ Hours per week? _____ Moderate occupational and
recreational exercise? _____ Sedentary work and light exercise only? _____
12. What additional information should the doctor have about you? _____

13. Comments

Patient's signature

HOUSTON CARDIOVASCULAR ASSOCIATES



Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
 - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
 - We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
 - Sale of your information
 - Most sharing of psychotherapy notes
-

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.
-

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or maintain psychotherapy notes at this practice.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 01/01/2014

This Notice of Privacy Practices applies to the following organizations.

*Privacy Contact: Daniel Godbout, 713-558-9525
6400 Fannin, Suite 3000, Houston, TX 77030
dgodbout@houstoncardiovascular.com*

