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 Amercian ☐ 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:

	Name	Relationship	Phone
	JANE DOE	*SPOUSE*	*(713) 555-5555*
1)			
2)			
3)			

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.