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 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: _____ Other Phone: _____

Work Phone: _____ Employer: _____

Employer's Address _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Alternate # _____

_____ _____

Name of Patient Medicare Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ /Houston Cardiovascular Associates for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature Date

Pt's with Medigap/secondary insurance policy, please read and sign the following:

_____ _____

Name of Patient Medigap/secondary insurance Number

I request that payment of authorized Medigap/secondary insurance benefits be made either to me or on my behalf to Dr._____ /Houston Cardiovascular Associates for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (name of Medigap/secondary insurer) any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature Date

Houston Cardiovascular Associates

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

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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.

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

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 9 10 11 12 College 1 2 3 4 Masters Ph.D. Others
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: cirle 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

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Houston, TX 77030

713-790-0841
www.houstoncardiovascular.com

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