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 ______________

Primary/Secondary Language: ______________

Preferred Language: ______________

Preferred choice of Communication Method

Email: __________

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.

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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.