PATIENT INTRODUCTION

PLEASE PRINT

DATE_____

PATIENT_____ SOCIAL SECURITY # _____
FIRST MIDDLE LAST

HOME ADDRESS_____ HOME PHONE #_____

CELL PHONE #_____ EMAIL ADDRESS _____

CITY/STATE _____ ZIP _____

SEX: ☐ M ☐ F AGE: _____ BIRTH DATE_____ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

PATIENT EMPLOYED BY_____ BUS. PHONE_____

ADDRESS_____ OCCUPATION_____

CITY/STATE_____ ZIP_____

(Please include guarantor's date of birth and social security number, if guarantor is different from patient)

RESPONSIBLE PARTY **SOCIAL**

(IF DIFFERENT THAN ABOVE)_____ **SEC. #**_____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN

BIRTHDATE_____

HOME ADDRESS_____ HOME PHONE _____

CELL PHONE _____

CITY/STATE_____ ZIP _____

EMPLOYED BY _____ BUS. PHONE _____

BUSINESS ADDRESS_____

CITY/STATE_____ ZIP_____

HEALTH INSURANCE COVERAGE: ☐ MEDICARE #_____ MEDICAID #_____

☐ HMO_____ _____

COMPANY NAME GROUP # ID#

☐ OTHER COVERAGE_____ _____

COMPANY NAME GROUP # ID#

COMPANY ADDRESS_____

CITY/STATE_____ ZIP_____

IN CASE OF EMERGENCY, NOTIFY _____ PHONE #_____

YOUR PHARMACY_____ PHONE #_____

REFERRED BY_____

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to physician of benefits due me for his services as described above. I understand I am financially responsible for charges not covered by this authorization.

_____

DATE Signature

RELEASE OF INFORMATION: I hereby authorize the physician and/or supplier to release any information required to process this claim form.

_____

DATE Signature

MEDICARE PATIENTS ONLY:

I authorize payment to be made to the physician. I authorize any holder of medical information about me to release to my insurance carrier and/or HCFA and its agents and/or my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

Signature:_____

Houston Cardiac Clinic Patient Questionnaire

Name: _____ Age: ____ DOB: _____ Today's date: _____
Were you referred by another doctor?_____ Who?_____

What is the main reason for seeing the doctor today? *(example: check-up, chest pain, etc.)*

Past Medical History and chronic medical problems:

	Problem	Year first diagnosed
1.		
2.		
3.		

Have you been diagnosed with a heart problem?	Yes	No
Have you had a "heart attack"?	Yes	No
Have you been diagnosed with "heart failure"?	Yes	No
Have you been diagnosed with having an abnormal heart rhythm?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have diabetes?	Yes	No
Do you have high cholesterol?	Yes	No

Past surgical history: Have you ever had surgery? (please specify)

	Type of surgery	Year of surgery
1.		
2.		
3.		

Family Medical History: Describe

Does heart disease run in your family? Yes No – (specify)

Father
Mother
Siblings

Social History:

1. Marital Status: Married_____ Single_____ Divorced_____ Widowed_____
2. Occupational: Retired_____ Unemployed_____ Disabled_____ Working_____ Job Title:
3. Risk Factors: Do you smoke? Yes No How many packs per day?_____
   Do you drink alcohol? Yes No How many drinks per day?_____
   Have you ever used illegal drugs? Yes No

Recent symptoms:

1. Do you have chest pain?	Yes	No
2. Do you have shortness of breath?	Yes	No
With exertion?	Yes	No
While lying flat in bed?	Yes	No
Does it wake you at night?	Yes	No
3. Have you had any swelling in your legs?	Yes	No
4. Do you routinely develop pain in your legs when you walk?	Yes	No
5. Have you passed out recently?	Yes	No
6. Have you felt your heart beating fast in your chest?	Yes	No

Medications:

1. Please list any medication allergy that you have and the reaction it causes: *(example: Penicillin - rash)*

2. Please list any medicines that you take and the dose:

	Name	Dose	Taken how often?
Example:	*Metaprolol*	*50mg*	*twice daily*
1.			
2.			
3.			

HOUSTON CARDIAC CLINIC

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENT PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____

Who has Authorized access to your Protected Health Information?

Name:	Phone:
1.	
2.	
3.	
4.	
5.	

_____ _____

Signature of Patient or Legal Guardian Date:

NOTICE OF PRIVACY PRACTICES

Houston Cardiac Clinic
P.A 925 Gessner, Suite 525 Houston, TX 77024
Phone: 713-827-7680
Fax: 713-827-0210

This notice became effective on April 14, 2003

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.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT HOUSTON CARDIAC CLINIC, P.A AT 713-827-7680.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, payment for your health care, or health care (clinic) operations and for other purposes that are permitted or required by law. It also describes you rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical mental health or condition and related to health care services.

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

1. Uses and Disclosures of Protected Health Information

This medical practice collects health information about you and stores it in a chart and on a computer and in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The Law permits us to use or disclosure your health information.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physician who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a radiologist or pathologist, or a laboratory that performs a test) who, at the request of your physician, becomes involved in your case by providing assistance with your health care diagnosis or treatment to your physician. We may also disclose medical information to a member of your family or others who can help you when you are sick or injured, or after you die.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care service. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as : making determination of eligibility or coverage for insurance benefits, reviewing activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare (Clinic) Operations: We may use or disclose, as-needed, your protected health information in order to support the professional and business activities of your physician's practice. These activities includes, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

For example, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information necessary, to contact you to remind you of your appointment. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone, or we may use and disclose this information to get your health plan to authorize services or referrals.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing service that perform administrative for us, transcription services, medical reviews, legal services , including fraud , abuse detection, compliance programs, business planning management and telephone answering service) for the practice. Whenever and arrangement between our office and a business associate involves the use disclosure of your protected health information, we will have a written contract that contains terms that protect the privacy of your protected health information.

We may also share your information with other health care providers, health care clearing houses or health plans that have relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure in your best interest. In the case, only the protected health information that is relevant to your health care will be disclosed. We may use and disclose your protected health information in the following instance.

Others Involved in Your Healthcare

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree to object to such a disclosure, we may disclose such information as necessary if we determine that it is your best interest best on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements o
f the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclosure your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administrations: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors and organ donation: We may disclose protected health information to a coroner medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: If you choose to participate in medical or scientific research, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and establish protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify o apprehend and individual.

Military Activity and National Security: When the appropriate condition apply, we may use or disclose protected health information of individuals who are Armed Forced personnel (1) For activities deemed necessary by appropriate military command authorities (2) for the purposes of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers Compensation: Your protected health information may be disclosed by us as authorized to comply with workers compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a received your protected health information in the course of providing care to you.

Required Users and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et.seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decision about your health care. The request must be made in writing to **Houston Cardiac Clinic, P.A.** If you request a copy of your medical record, your physician's office will provide you a copy within 30 days.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our office if you have questions about access to your medical records.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it its needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request to the manager of your physician's clinic.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request and explanation from you as to the basis for the request. Please make this request in writing to our office **Houston Cardiac Clinic, P.A 925 Gessner, Plaza Medical 4, suite 525, Houston, Texas 77024.**

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information for the purpose of correcting an error or misinformation. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file statement of disagreement with us and that statement will become part or your medical record. Your physician will provide you with a copy of any such rebuttal. Please contact our office if you have any questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes to legal or regulatory agencies. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Complaints

Complaints about this Notice of Privacy Practice or how this medical practice handles your health information should be directed to Houston Cardiac Clinic , P.A.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

PRINT NAME : _____

SIGNATURE : _____

DATE : ____/___/____

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____[Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange