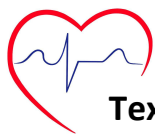
**PATIENT INFORMATION & MEDICAL SCREENING FORM**

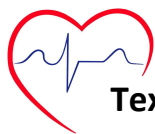
Today's date:			
<b>Demographics</b>			
Name - Last (Apellido)		First (Nombre)	MI
Address Line 1: (Direccion)		Date of Birth :( Fecina de Nacimiento)	
Address Line 2:		Gender: (Sexo) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
City: (Cuidad)		State:(Estado)	Zip: (Codigo Postal)
Home Phone: (Numero de Casa)		SSN: (Numero de Seguro Social)	
Cell Phone: (Numero de Trabajo)		Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced (Estado <input type="checkbox"/> Widowed <input type="checkbox"/> Other Civil)	
Work Phone:		Employment Status: (Estado de Empleo)	
Which phone is primary? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Student	
Do you want to be Web Enabled? <input type="checkbox"/> No <input type="checkbox"/> Yes		Employer Name ( Nombre del Empleador)	
Primary Care Physician: (Numbre de Medico)		Occupation:(If retired, list previous occupation) (Ocupacion)	
Phone: (Numero de Telefono)		Ethnicity:(Origin Ethnico) <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Do not wish to disclose <input type="checkbox"/> Other:	
Preferred Pharmacy: Name/City		Resident of Nursing Facility? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Add'l/Mail Order Pharmacy: Name/City		If Yes, where:	
How did you hear about us? Radio <input type="checkbox"/> TV <input type="checkbox"/> Social Media <input type="checkbox"/> Website <input type="checkbox"/> Billboard <input type="checkbox"/> Other <input type="checkbox"/>			
<b>Emergency and HIPAA Contact Information</b>			
Check the HIPAA box if this person has permission to obtain your Private Health Information such as, appointment information, test results, medication information, demographic information, etc.			
Name	Phone #	Relationship	Permission(s)
	(Home)		<input type="checkbox"/> HIPAA
	(Cell)		<input type="checkbox"/> Emergency
	(Home)		<input type="checkbox"/> HIPAA
	(Cell)		<input type="checkbox"/> Emergency
<b>Insurance Information</b>			
Primary Carrier: (Nombre de la Copania de a Segurancia Primario)	Subscriber #: (Numero de Policia)	Group # (Numero de Grupo)	
Name of Insured (Nombre de Suscriptor)	DOB of Insured: ( Fecha de Nacimiento)	Relationship: (Relacion)	
Secondary Carrier: (Nombre de Secundario)	Subscriber #:	Group #	
Name of Insured	DOB of Insured	Relationship:	
<b>Acknowledgement</b>			
Once signed, this document and the information herein becomes a permanent part of my medical record. By signing below, I certify that the information entered above is true and correct to the best of my knowledge. It is my responsibility to notify Texoma Cardiovascular Associates immediately if there are any changes or updates to this information. I also understand that providing inaccurate or false information on this form could result in discharge from the practice and/or legal consequences. I also agree to the office policies of Texoma Cardiovascular Associates including financial responsibilities, which are available upon request.			
Printed Name (Nombre)			
Signature of Patient or legal guardian ( Firma)		Relationship (Relacion)	Date ( Fecha)

[illegible]



## Texoma Cardiovascular Associates

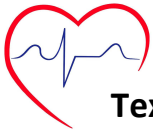
Patient Name:		DOB:	
<b>PATIENT'S PERSONAL HISTORY</b>			
CONFIDENTIAL RECORD: INFORMATION WILL NOT BE RELEASED WITHOUT AUTHORIZATION			
Date of last physical exam:		Doctor:	
Family or Referring Physician:		Reason for Today's Visit:	
Immunizations Current:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dates of Last:	Tetanus Shot:	Flu Shot:	Pneumonia Shot:
<b>Personal Habits</b>			
Do you use tobacco? Type:	<input type="checkbox"/> Never	<input type="checkbox"/> I quit -When? Packs per day? How long?	<input type="checkbox"/> I still smoke/use Packs per day? How long?
Do you drink alcohol? Type:	<input type="checkbox"/> Never	<input type="checkbox"/> I quit-When? Drinks per day? How long?	<input type="checkbox"/> I still drink Drinks per day? How long?
Do you use any street drugs? Type:	<input type="checkbox"/> Never	<input type="checkbox"/> I quit - When? How long?	<input type="checkbox"/> I still use How long?
<b>Previous Surgeries</b>			
Please list all surgeries that you have had			
Type	Year	Type	Year
<b>Chronic Medical Problems</b>			
Check the box beside the medical problems <b>YOU</b> have had and indicate for how long, write in any that are not listed:			
Problem	How Long?	Problem	How Long?
<input type="checkbox"/> Diabetes		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Cancer:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
<b>Women Only</b>		<b>Men Only</b>	
Are you having regular periods?		Have you had prostate problems?	
Date of last period:			
How many pregnancies?		Have you had any hernias?	
Date of last pap smear:			
Have you had an abnormal pap smear?		Date of last PSA test:	
Date of last mammogram:			



# Texoma Cardiovascular Associates

<b>Patient Name:</b>		<b>DOB:</b>	
<b>Review of Systems</b> (Check yes or no and explain)			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any fevers, sweats, or weight changes?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any stomach or bowel complaints?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any headaches, dizzy spells, or weakness?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problems with eyes?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problems with ears, nose, or throat?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any chest pain?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any shortness of breath or cough?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problem with bladder or kidneys?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problem with back, joints, or feet?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problem with nerves, depression, etc?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any increase in thirst?		

Family History								
		If Living		If Deceased				
		Age	Health	Age at Death	Cause			
<b>Father</b>								
<b>Mother</b>								
<b>Brother/Sisters</b>	<b>Sex</b>	<b>Age</b>	<b>Health</b>	<b>Age at Death</b>	<b>Cause</b>			
	M F							
	M F							
	M F							
	M F							
<b>Sons/Daughters</b>	<b>Sex</b>							
	M F							
	M F							
	M F							
	M F							
<b>Do you know of any BLOOD RELATIVE who has had?</b> <b>Mark an "X" in the appropriate box.</b>				<b>Grandparent</b>	<b>Father</b>	<b>Mother</b>	<b>Sibling</b>	<b>Child</b>
Stroke								
Cancer								
Heart Attack								
Diabetes								
Kidney Disease								
High Blood Pressure								
Thyroid Problem or Goiter								
Bleeding Disorder								
Tuberculosis								
Other:								
Other:								
Other:								



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## **OFFICE POLICIES**

### **FINANCIAL & INSURANCE POLICY**

**If you have a Texoma Cardiovascular Associates participating insurance:** At the time of your appointment your copay, co-insurance and/or deductible will be collected. After **Texoma Cardiovascular Associates** bills your insurance, the balance remaining will be due, unless arrangement is made for payment with the Financial Counselor.

**If you have insurance that Texoma Cardiovascular Associates does not participate in:** You are responsible for payment of your bill at the time of service. **Texoma Cardiovascular Associates** will, however, file non-assigned claims to these insurance companies as a courtesy to you.

**If you do not have insurance:** At the time of your appointment, you will be expected to pay the discounted financial portion in full at time of service.

### **Consent for Treatment**

The patient agrees and consents to general medical treatment by Texoma Cardiovascular Associates professionals and understands and consents to the review and use of his/her medical records.

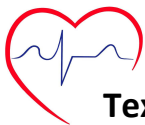
### **Authorization and Assignment of Benefits**

**Release of Medical Information Authorization:** I authorize **Texoma Cardiovascular Associates** to release pertinent information about my medical condition for the purpose of securing health insurance benefits information, authorization or payment for services and tests. I will provide a current copy of any insurance identification cards policy numbers and demographic information to **Texoma Cardiovascular Associates** upon request. I also authorize **Texoma Cardiovascular Associates** to act as my representative and on my behalf to secure all authorizations necessary from my insurance company regarding procedures or orders involving a surgical procedure or medical test performed by **Texoma Cardiovascular Associates** or an associate, including, if necessary, any appeal of a denial of benefit and in billing my insurance carrier for medications and/or supplies. I understand that I may revoke this authorization at any time by giving **Texoma Cardiovascular Associates** a written statement to withhold my personal and medical information from that time forward.

**Assignment of Benefits:** I request that payment of authorized insurance benefits be made on my behalf to **Texoma Cardiovascular Associates** for any services or tests provided to me by **Texoma Cardiovascular Associates**. I understand and agree that a copy of this authorization and/or assignment of benefits, when signed by me, my authorized representative, or a legal guardian, may be sent to my insurance company or health care provider if requested. A copy of this authorization and assignment of benefits shall be as valid as an original, and **Texoma Cardiovascular Associates** may refer to my signature on file regarding this authorization and/or this assignment of benefits.

By my signature, or an authorized signature, below, I understand and agree to the following:

- I am financially responsible to **Texoma Cardiovascular Associates** for any charges not covered by my health care benefits and for any portion of any charges denied by my health care benefits, in accordance with applicable law;
- I am responsible to notify **Texoma Cardiovascular Associates** for any changes in my address and in my health care coverage;
- In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim and this may result in balances billed to me, such as deductibles, pre-existing clauses, etc.
- I acknowledge receiving a copy of **Texoma Cardiovascular Associates** Notice of Privacy Practices;
- I understand that **Texoma Cardiovascular Associates** will endeavor to obtain authorization from my insurance provider to reimburse **Texoma Cardiovascular Associates** for services and/or tests that may be covered. However, there is no guarantee that **Texoma Cardiovascular Associates** will receive authorization or payment from my insurance provider.



## Texoma Cardiovascular Associates

**Prescriptions Refill:** Plan on a 72-hour turn-around time for routine refills, and place a call to the pharmacy to see if the medication is ready. When you request a refill via online or telephone, please include all medications that need to be refilled within the next thirty days. When you come into the office, please ask for refills of prescription medications that you keep on hand. If you have mail-in pharmacy paperwork, we will be happy to assist you in completing the paperwork. However, it is the patient's responsibility to forward the paperwork or prescriptions to their pharmacy.

**Sample Refill:** Plan on a 24-hour turn-around time for sample refills.

### MEDICAL RECORD REQUEST POLICY

Please allow 3-5 business days to complete requests for medical records. **Texoma Cardiovascular Associates** may charge a reasonable and customary fee for all medical record requests that will be collected prior to records being released.

### PATIENT RIGHTS & RESPONSIBILITIES

As a patient of **Texoma Cardiovascular Associates**, you have specific rights and responsibilities during your care. We believe that an informed patient, taking an active interest in his or her care, is happier emotionally and headed for a more satisfactory outcome. **Texoma Cardiovascular Associates**, its physicians and staff treat all persons without regard to race, creed, national origin, age or disability.

#### **PATIENT RIGHTS**

1. You will receive medically indicated care regardless of race, creed, gender, national origin or source of payment.
2. You have a right to considerate, respectful care as an individual at all times and under all circumstances.
3. You have a right to a safe environment for your treatment and care. You also have a right to care and accommodations that take into consideration physical disabilities that would otherwise impact your care.
4. You have a right to personal and informational privacy, within the law.
5. You have a right to complete information from your primary practitioner on your diagnosis, treatment, and any known prognosis.
6. You have a right to reasonable, informed participation in decisions on your care.
7. You may refuse treatment to the extent permitted by law, although it may result in the termination of the physician-patient relationship.
8. You are entitled to an explanation of **Texoma Cardiovascular Associates** rules and regulations for patient conduct as well as the office's systems for handling patient complaints.

#### **PATIENT RESPONSIBILITIES**

1. You should provide, as fully as you can, accurate and complete information on present complaints, past illnesses and hospitalizations, medications and other matters regarding your health. You are also responsible for reporting any changes to your practitioner.
2. You should tell the staff if you do not understand explanations of your care or what is expected of you.
3. You are responsible for following the treatment plan your physician recommends.
4. You are responsible for your actions if you refuse treatment or do not follow your physician's orders.
5. You are responsible for having your bill paid as promptly as possible.
6. You are responsible for following **Texoma Cardiovascular Associates** rule for patient care and conduct.

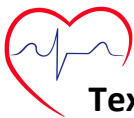
*By signing below, I hereby consent to treatment necessary for the care of the patient indicated on this form. I certify that the information I have provided is truthful, correct and complete, and I understand and agree to the terms of this authorization and assignment of benefits. I acknowledge that any inaccurate information provided or omission of accurate information may delay the processing of my services and tests and shall result in **Texoma Cardiovascular Associates** billing me for the services and tests provided.*

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date



**RELEASE OF INFORMATION FOR MEDICAL RECORDS**

Patient Name:	Patient DOB:
Physician or Entity/Facility to receive or release Information:	Fax:
Physician or Entity/Facility to receive or release Information:	Fax:
Physician or Entity/Facility to receive or release Information:	Fax:
Physician or Entity/Facility to receive or release Information:	Fax:
Person or Entity to receive or release information:	
Please check the type of information to be released:	
<div style="display: flex; flex-wrap: wrap;"><div style="width: 50%;"><input type="checkbox"/> Complete Medical Record</div><div style="width: 50%;"><input type="checkbox"/> Lab Results</div><div style="width: 50%;"><input type="checkbox"/> X-Ray Results/Film</div><div style="width: 50%;"><input type="checkbox"/> Billing Record</div><div style="width: 50%;"><input type="checkbox"/> Notes/Results for Date(s) of Service: _____ to _____</div><div style="width: 50%;"><input type="checkbox"/> Consultation Reports</div><div style="width: 50%;"><input type="checkbox"/> Immunization</div><div style="width: 50%;"><input type="checkbox"/> Other (specify): _____</div></div>	
Please check the reason the above information is released:	
<div style="display: flex; flex-wrap: wrap;"><div style="width: 50%;"><input type="checkbox"/> Transfer to another physician</div><div style="width: 50%;"><input type="checkbox"/> Continuing/Establishing Care</div><div style="width: 50%;"><input type="checkbox"/> Personal File</div><div style="width: 50%;"><input type="checkbox"/> Disability Benefits</div><div style="width: 50%;"><input type="checkbox"/> Legality Purposes</div><div style="width: 50%;"><input type="checkbox"/> Other (specify): _____</div></div>	
<p>✓ I understand that the specific information to be disclosed may include history of DRUG or ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), and laboratory test results, treatment progress or any other such related information.</p> <p>✓ I understand that my treatment or payment for services will not be denied should I elect not to sign the authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. However, no protected information will be released without a signature. Also, I understand that information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer protected by the Standards of Privacy of Individually Identifiable Health Information. (45 CFR parts 160 &amp; 164)</p> <p>✓ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. The authorization will expire in 180 days from the date of my signature on or otherwise specified by date, event, or condition as follows: _____</p> <p>✓ I further authorize that a photocopy of this authorization is acceptable as an original.</p> <p>✓ I understand I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing law.</p>	
Signature of Patient or Legal Representative	Relationship to Patient      Date
<p><i>PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal &amp; State Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500, in case of a first offense, and not more than \$5,000 in the case of each subsequent offense.</i></p>	