Texoma Cardiovascular Associates

Mahjoobi ☐ **Turner** ☐

PATIENT INFORMATION & MEDICAL SCREENING FORM

Today's date:

Demographics

Name - Last (Apellido) First (Nombre) MI	Date of Birth :(Fecina de Nacimiento)
Address Line 1: (Direccion)	Gender: (Sexo) ☐Male ☐Female ☐Other
Address Line 2:	SSN: (Numero de Seguro Social)
City: (Cuidad) State:(Estado) Zip: (Codigo Postal)	Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other (Estado Civil)
Home Phone: (Numero de Casa) — Okay to leave message? ☐Brief ☐Extended ☐None	Employment Status: (Estado de Empleo) ☐Full-Time ☐Part-Time ☐Retired ☐Student
Cell Phone: (Numero de Trabajo) — Okay to leave message? ☐Brief ☐Extended ☐None	Employer Name (Nombre del Empleador)
Work Phone: — Okay to leave message? ☐Brief ☐Extended ☐None	Occupation:(If retired, list previous occupation) (Ocupacion)
Which phone is primary? ☐Home ☐Cell ☐Work	
Do you want to be Web Enabled? ☐No ☐Yes Email Address:	Ethnicity:(Origin Ethnico) ☐African American ☐Asian ☐Caucasian ☐American Indian ☐Hispanic ☐Do not wish to disclose ☐Other:
Primary Care Physician: (Numbre de Medico) — **Phone: (Numero de Telefono)**	
Preferred Pharmacy: Name/City — Phone:	Resident of Nursing Facility? ☐No ☐Yes If Yes, where:
Add'l/Mail Order Pharmacy: Name/City — Phone:	
How did you hear about us? Radio ☐ TV ☐ Social Media ☐ Website ☐ Billboard ☐ Other ☐	

Emergency and HIPAA Contact Information

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) (Cell)		☐ HIPAA ☐ Emergency
	(Home) (Cell)		☐ HIPAA ☐ Emergency

Insurance Information

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:

Acknowledgement

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)

Texoma Cardiovascular Associates

Patient Name:	DOB:

Current Medications

*List **ALL** current medications including over the counter medications/vitamins/herbals/supplements*

Medication Name	Dosage	# Times Daily

Allergies to Medication & Food

Do you have any allergies to medication and/or food? ☐No ☐Yes, please explain below

Type	Reaction

Texoma Cardiovascular Associates

Patient Name:	DOB:

PATIENT'S PERSONAL HISTORY

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:	☐ Yes ☐ No
Dates of Last: Tetanus Shot:	Flu Shot: Pneumonia Shot:

Personal Habits

Do you use tobacco? Type:	☐ Never	☐ I quit -When? Packs per day? How long?	☐ I still smoke/use Packs per day? How long?
Do you drink alcohol? Type:	☐ Never	☐ I quit-When? Drinks per day? How long?	☐ I still drink Drinks per day? How long?
Do you use any street drugs? Type:	☐ Never	☐ I quit - When? How long?	☐ I still use How long?

Previous Surgeries

Please list all surgeries that you have had

Type	Year	Type	Year

Chronic Medical Problems

Check the box beside the medical problems **YOU** have had and indicate for how long, write in any that are not listed:

Problem	How Long?	Problem	How Long?
☐ Diabetes		☐ High Blood Pressure	
☐ Kidney Disease		☐ Lung Disease	
☐ Heart Disease		☐ Cancer:	
☐ Other:		☐ Other:	
☐ Other:		☐ Other:	
☐ Other:		☐ Other:	
☐ Other:		☐ Other:	

Women Only		Men Only	
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:			

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Patient Name:	DOB:

Review of Systems (Check yes or no and explain)		
☐ Yes ☐ No	Any fevers, sweats, or weight changes?	
☐ Yes ☐ No	Any stomach or bowel complaints?	
☐ Yes ☐ No	Any headaches, dizzy spells, or weakness?	
☐ Yes ☐ No	Any problems with eyes?	
☐ Yes ☐ No	Any problems with ears, nose, or throat?	
☐ Yes ☐ No	Any chest pain?	
☐ Yes ☐ No	Any shortness of breath or cough?	
☐ Yes ☐ No	Any problem with bladder or kidneys?	
☐ Yes ☐ No	Any problem with back, joints, or feet?	
☐ Yes ☐ No	Any problem with nerves, depression, etc?	
☐ Yes ☐ No	Any increase in thirst?	

Family History						
		If Living		If Deceased		
		Age	Health	Age at Death	Cause	
Father						
Mother						
Brother/Sisters	**Sex**	**Age**	**Health**	**Age at Death**	**Cause**	
	M F					
	M F					
	M F					
	M F					
Sons/Daughters	**Sex**					
	M F					
	M F					
	M F					
	M F					

Do you know of any BLOOD RELATIVE who has had? Mark an "X" in the appropriate box.	Grandparent	Father	Mother	Sibling	Child
Stroke					
Cancer					
Heart Attack					
Diabetes					
Kidney Disease					
High Blood Pressure					
Thyroid Problem or Goiter					
Bleeding Disorder					
Tuberculosis					
Other:					
Other:					
Other:					

Texoma Cardiovascular Associates

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.

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 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

Texoma Cardiovascular Associates

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:

☐ Complete Medical Record ☐ Lab Results ☐ X-Ray Results/Film ☐ Billing Record

☐ Notes/Results for Date(s) of Service: _____to_____ ☐ Consultation Reports ☐ Immunization

☐ Other (specify):

Please check the reason the above information is released:

☐ Transfer to another physician ☐ Continuing/Establishing Care ☐ Personal File ☐ Disability Benefits ☐ Legality Purposes

☐ Other (specify):

✓ 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 ACUIRED IMMUNE DEFICIENCY SYDROME (AIDS), and laboratory test results, treatment progress or any other such related information.

✓ 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 & 164)

✓ 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:

_____

✓ I further authorize that a photocopy of this authorization is acceptable as an original.

✓ I understand I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing law.

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal & 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.