PATIENT INFORMATION

ACCOUNT # _____

PRIMARY DOCTOR: Phone Number:	***Referring Doctor***: Phone Number:

Patient Last Name First Name Initial	Sex	Age	Marital Status S M W D Sep	Birthdate	Home Phone ( )
Address Apt City State Zip					Cell Phone ( )
E-mail address (optional)			Social Security #		Driver´s License #
Employer			Occupation		Business Phone ( )
Employer Address			City	State	Zip
Pharmacy Name			Pharmacy Phone ( )		Pharmacy FAX ( )
Spouse Last Name First Name Initial			Social Security #		Birthdate

PERSON OR COMPANY RESPONSIBLE FOR PAYMENT:

Last Name First Name Initial	Relationship to Patient	
Address	Home Phone ( )	Social Security #
City State Zip	Work Phone ( )	Driver´s License #
Nearest Family Member Not Residing With You: Relationship	Street / City / State / Zip	Phone ( )

IN CASE OF EMERGENCY CONTACT:

Last Name First Name Initial	Relationship	Phone ( )

HEALTH INSURANCE INFORMATION:

1st Insurance Company Name	Name of Insured	Social Security #	Birthdate
Send Claim To:	Employer	Relationship to Insured Self Spouse Parent Employer Other	
City State Zip	Employer Address	Group#	Policy # or Certificate #
2nd Insurance Company Name	Name of Insured	Social Security #	Birthdate
Send Claim To:	Employer	Relationship to Insured Self Spouse Parent Employer Other	
City State Zip	Employer Address	Group#	Policy # or Certificate #

All professional services rendered are charged to the patient and remain the patient´s responsibility regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

HMO & PPO PATIENTS: **It is the patient´s responsibility to have any required referral from the primary care doctor and to furnish complete insurance information for this office. If the insurance information or referral is not available, the patient will be responsible for the charges and payment in full will be collected.** ***A $50.00 Fee will be assessed for missed appointments without 24 hour notice.***

I hereby assign payment of medical insurance benefits to the physician or physicians that rendered treatment. I understand that I am financially responsible for all charges whether or not paid by said insurance company(s). I authorize the release of medical or other information to my insurance company(s)

_____ _____

DATE PATIENT / OTHER LEGALLY RESPONSIBLE PERSON (Signature)

PATIENT HISTORY WORKSHEET

ACCOUNT # _____

Patient Name Last Name	Sex M F	Age	Marital Status S M W D Sep	# Children	Birthdate / /
Primary Care (Family) Doctor Name Address City State Zip					Phone#
Other physicians you are currently seeing:					
Reason for today's visit:					
Allergies:					
What type of work do you do?				Disabled? Y N	Retired? Y N
Have you ever smoked? Y N	If yes, How many packs per day?	How long?	If yes, When did you quit?		
Have you ever used alcohol? Y N	If yes, How many drinks per week?	How long?	If yes, When did you quit?		
Drugs, other than prescribed?		Do you have an Advanced Directive (Living Will)? Y N	In an emergency, Would you accept blood or blood products? Y N		

M.D. Use Only _____

_____

_____

_____

PLEASE ANSWER THE QUESTIONS BELOW ABOUT YOURSELF:

	Y	N		Y	N
Arthritis			Emphysema/COPD		
Skin Disorder			Stomach Problems or Ulcers		
Heart Attack			Kidney Disease		
Heart Murmur			Liver Disease/ Gallbladder Disease		
Congestive Heart Failure			Cancer		
Other Heart Disease			Stroke		
Rheumatic Fever			Prostate Problems (Men Only)		
Lung Disease			Urinary Problems		
Irregular Heart Rhythm			Asthma		

High Blood Pressure			Treated with: o Diet o Medication		
Diabetes			Treated with: o Diet o Pills o Insulin		
High Cholesterol Levels			Treated with: o Diet o Medication		
Angina			How is it relieved?		
Thyroid Problems			Treated with medication?	Y	N

WOMEN, PLEASE ANSWER THE FOLLOWING QUESTIONS:

	Y	N		
Menopausal?			Date of last menstrual period	/ /
Are you taking hormones?				
Is there a possibility that you are pregnant?				

***** **OVER PLEASE** ***** **SEE OTHER SIDE** *****

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES?

PROCEDURE	PLACE IT WAS PERFORMED	DATE	DOCTOR PERFOMED SURGERY
Heart Catheterization / Angiogram			
Angioplasty (Balloon Procedure) / Stent			
Heart or Valve Surgery			
Carotid Endarterectomy			
Femoral Popliteal Bypass			
Pacemaker			
Implanted Defibrillator			
Echocardiogram			
Treadmill Test			
24 Hour Heart Monitor			

- ***PLEASE PROVIDE A COPY OF YOUR PACEMAKER, VALVE OR ICD CARD TO OUR RECEPTIONIST.***

PLEASE LIST ANY SURGERIES YOU HAVE HAD THAT ARE NOT LISTED ABOVE:

SURGERY	PLACE IT WAS PERFORMED	DATE	DOCTOR PERFOMED SURGERY

	Y	N	
Do you exercise?			What type?
			How often?

When was your cholesterol level checked last?	

PLEASE ANSWER THE QUESTIONS ABOUT MEDICAL SYMPTOMS / CONDITIONS YOU HAVE OR HAD WITHIN THE PAST 3 MONTHS:

	Y	N		Y	N		Y	N
Pain with breathing			Shortness of breath			Hepatitis		
Headaches			Unusual fatigue			HIV positive		
Episodes of "passing out"			Palpitations			Feeling light-headed / Dizzy		
Anxiety / Depression			Swelling at legs / ankles			Clots in lungs		
Chest Pressure / Pain			Unusual sweating			Heartburn		
Numbness / Tingling			Fast heart rate					

Other?	

Have you had chemical exposure that may be harmful to your health?	

How many pillows do you sleep on?	

	Y	N		Y	N		Y	N
Do you awaken breathless at night?			Do you snore?			Do you fall asleep easily during the day?		

HISTORY OF FAMILY ILLNESSES. PLEASE CIRCLE 'Y' FOR YES 'N' FOR NO:

	MOTHER		FATHER		SISTERS		BROTHERS	
Heart Attack	Y	N	Y	N	Y	N	Y	N
Diabetes	Y	N	Y	N	Y	N	Y	N
High Cholesterol	Y	N	Y	N	Y	N	Y	N
Stroke	Y	N	Y	N	Y	N	Y	N
Cancer	Y	N	Y	N	Y	N	Y	N
High Blood Pressure	Y	N	Y	N	Y	N	Y	N
Living?	Y	N	Y	N	Y	N	Y	N
Cause of death if applicable								

NUCLEAR STUDY PATIENTS ONLY:

	Y	N
Have you had anything to eat or drink since last night?		
Have you had any Nuclear Medicine studies in the last week?		
Which doctor sent you for this test?		

LIST YOUR MEDICATIONS:

_____ _____

_____ _____

Communication Authorization and Designated Party Release

You may give Cardiovascular Associates of San Antonio, P.A. written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person/persons to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, testing, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or to another party that you designate.

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Acct #: _____

I authorize Cardiovascular Associates of San Antonio to disclose my protected health information to: (*write name of person/persons who you want to receive your protected health information):*

Name(s): _____

Phone Number(s): _____

Relationship to Patient: _____

Primary Care Physician(s): _____

I authorize Cardiovascular Associates of San Antonio to obtain my protected health information from:

Primary Care Physician(s): _____

Specialist(s): _____

Hospital(s): _____

At my request, I also authorize Cardiovascular Associates to communicate my protected health information to me via the following methods:

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Phone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Other: _____
_____

*Authorized Signature: _____ Date: _____

***This form will expire 1 year from authorized signature date above.**

Cardiovascular Associates of San Antonio Financial Policy

Thank you for choosing Cardiovascular Associates of San Antonio. We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

1. Insurance. *We bill participating insurance companies as a courtesy to you. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage. By signing this form you authorize CVASA to release the necessary information in order to complete and process your insurance claims.*

2. Co-payments, co-insurance, and deductibles. *All co-payments, co-insurance, and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company and federally mandated. CVASA accepts cash, checks (in-state), and all major credit cards. A $25 NSF fee will be assessed for any returned checks. If for any reason you will not be able to pay your balance in full at the time of your appointment, you are responsible for contacting us in advance to make payment arrangements.*

3. Managed Care. *If you are enrolled in a managed care insurance plan (i.e. HMO) we must receive a referral prior to your scheduled appointment. If you chose to be seen without a referral, you will be scheduled as a private pay patient and payment will be due in full at the time of service.*

4. Updates. *Our staff will ask you to verify your billing information at each and every visit. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.*

5. Claims submission. *We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim within 60 days, you may be expected to pay the balance in full.*

6. Coverage changes. *If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits.*

7. Nonpayment. *Payment is due at time of service unless prior arrangements have been made. Patients with outstanding balances of 60 days or more must make payment arrangements prior to scheduling appointments. Accounts overdue 90 days or more will be forwarded to an outside collection agency (San Antonio Retail Merchants' Association). Accounts sent to an outside collection agency will have a 30% service fee added to the account.*

8. Missed appointments. *Missed appointments represent a cost to us, to you, and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We will charge a $50 fee for missed appointments or appointments cancelled with less than 24 hour notice.*

9. Refunds. *Patient/Guarantor credits will be retained on account to be credited toward future balances unless a written request for a refund is received.*

I have read and understand Cardiovascular Associates of San Antonio's payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party *Date*

If you need assistance or have questions, please contact our billing office at 210-225-4566. Our hours are 8:30am to 5:00pm CST, Monday through Friday.

CARDIOVASCULAR ASSOCIATES OF SAN ANTONIO, P.A.

CONSENT TO TREATMENT AND CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the patient identified below, or his or her legal guardian or representative, request and consent to the procedure and treatment that may be performed by physicians and other clinical staff of Cardiovascular Associates of San Antonio, P.A. (the "Association"), and which may include but are not limited to physical examinations, laboratory procedure, diagnostic procedures, and medical treatment or procedures rendered for the patient under the general and special instructions of the patient's physician.

I understand that as part of my healthcare, the Association originates and maintains records that may include my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment, and information payment for the provisions of health services. I understand and authorize this information to be utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other healthcare operations including: quality assessment through outcomes evaluations and development of clinical guidelines; reviewing competence of healthcare professionals through peer review and credentialing activities; and conducting fraud and abuse and compliance reviews. I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I understand that I may revoke this consent at any time in writing except that the Association has already taken action in reliance on this consent. I also understand that this consent is valid until revoked by me in writing.

_____ _____

Patient Signature or Legal Representative Date

_____

Print Patient Name or Legal Representative

Notice Concerning Complaints

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at one of the following addresses:

Texas State Board of Medical Examiners Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2018	**Cardiovascular Associates of San Antonio** Privacy Officer: Andrea Westby 1123 N. Main Ave, #110 San Antonio, TX 78212 (210) 225-4566

Assistance in filling a complaint is available by calling the following telephone number: **1-800-201-9353**

CARDIOVASCULAR ASSOCIATES OF SAN ANTONIO, P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

YOUR PROTECTED HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment, future care. Your medical record is the physical property of Cardiovascular Associates of San Antonio, P.A. (the "Association") but you have certain rights to restrict some of the uses or disclosures of the information in you medical record. The Association, however, has the right to use and disclose the information contained in you medical record in the process of providing treatment, receiving payment and performing other regular health operations such as:

- documenting and describing the care you received for legal purposes;
- communicating with other healthcare providers who may be involved in your case;
- educating health care professionals;
- conducting medical research;
- providing information for government and public health entities responsible for improving public health and welfare;
- evaluating and improving the care you receive and the outcomes achieved;
- billing and verifications of services provided to you; and
- Conducting other routine healthcare operations such as quality improvement studies and assessing healthcare provider competence.

EXAMPLES OF USES AND DISCLOSURES OF YOUR PHI

- Healthcare delivery and treatment:
  Information obtained from you by a physician, nurse of other healthcare professional is documented in you record and used for the assessment, evaluation, diagnosis and treatment of you medical condition (s). Following your treatment, this information may be provided to other healthcare professionals who may be involved in your care, such as other physicians, specialist, physical therapists, hospital based providers and/or other healthcare providers.
- Billing and payment:
  Your PHI is utilized to justify the level of care delivered to you and the change incurred for the services. This information generally accompanies the bill and is sent to our payers.
- Other healthcare operations:
  The Association may disclose you PHI to other individuals and business in order to perform day-to-day operations. These other individuals and business include business associates such as vendors and/or contractors used for billing and claims management, medical research, disease management, and quality improvement initiatives, as well as management services organizations, laboratories, other free standing diagnostic facilities and legal counsel. The Association requires all business associates to agree to appropriately protect the confidentiality of your PHI.

- Reminders and Treatment:

The Association may contact you to provide you with information that feel is useful or helpful to you, based on you PHI. For example, the Association may contact you (or instruct a specialist physician to whom you have been
referred to contact you) to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information on treatments you are already receiving.

- Other Uses and Disclosures:
  The Association may also utilize or disclose your PHI in order to communicate with or notify family members, relatives and others responsible for your health, and funeral directors. In addition, the Association may disclose you PHI through other communications and reports required to be made by healthcare professionals such as the public health department, law enforcement, the Food and Drug Administration, organ procurement organizations, correctional institutions, and workers compensation, where applicable.

Other uses and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that the Association has already taken action in reliance on your prior authorization.

YOUR RIGHTS CONCERNING PHI

Except as otherwise provided by law, you have the right to:

- receive a paper copy of this NOTICE OF PRIVACY PRACTICES if you have agreed to receive it electronically;
- receive confidential communications of PHI if a request is submitted to the Association in writing;
- inspect and copy PHI or records about you in a designated record set as long as the PHI is maintained in the record set;
- ask the Association to amend PHI or records about you in a designated record set as long as the PHI or record is maintained in the record set (the Association is not required to change the information if it deems it to be accurate);
- receive an accounting of disclosures of PHI (a list of the disclosures made by the Association about you for reasons other than treatment, payment or health care operations); and
- request that the Association restrict uses or disclosures of you PHI. Though the Association is not required to agree to a restriction, to the extent that it does agree with your request, the Association may not use or disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law.

The Association is required by law to maintain the privacy and confidentiality of you protected health information and to provide you with notice of its legal duties and privacy practices with respect to such health information. The association is also required by law to abide by the terms of this NOTICE OF PRIVACY PRACTICES, allow you to review this NOTICE prior to granting consent, and notify you of changes/revisions to this NOTICE. If you believe your privacy rights have been violated, you may submit a written complaint to the Association or the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. The Association will not retaliate against you in any way if you choose to file a complaint.
This NOTICE OF PRIVACY PRACTICES is effective as of 05/01/2014 . For further information regarding PHI, please contact the Office Manager. Privacy Officer of the Association, at (210) 225-4566 Ext.110.

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES and have been given a copy to retain for my records

Patient Signature: _____ Date _____