

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Past Medical History**

Please circle your response below:

PAST MEDICAL HISTORY		
Aortic Aneurysm	Carotid Disease	Kidney Disease
A-Fib	Heart Failure	Heart Attack
Anemia	Clotting Disorder	Peripheral Arterial Disease
Angina	Coronary Artery Disease	Sleep Apnea
Arrhythmia	Diabetes	Stroke/TIA
Asthma	Heart Murmur	Syncope (Fainting)
Cancer	High Cholesterol	Thyroid Disease
Cardiomyopathy	High Blood Pressure	Varicose/Spider Veins
OTHER MEDICAL HISTORY		
Anxiety Or Depression	Easy Bruising/Bleeding	Phlebitis/Swelling
Arthritis	HIV/AIDS	Rheumatic Fever
Blood Clots in Veins/Lungs	Liver Problems/Hepatitis	Stomach/Intestinal Ulcers
COPD/Emphysema	Menopause	Tuberculosis
PAST CARDIAC SURGERIES		
AAA Repair	Cardioversion	LARIAT
Cardiac Ablation	Carotid Stent	Pacemaker
ASD Repair	Coronary Stent and/or Catheterization	Peripheral Stent
Coronary Bypass	Implantable Cardioverter Defibrillator	Valve Repair/Replacement

**Family History**

Please check appropriate boxes below:

Relationship	Alive/Deceased	Arrhythmia	Coronary Artery Disease	Clotting Disorder	Diabetes	Heart Attack	Heart Disease	Heart Failure	High Cholesterol	High Blood Pressure	Stroke/TIA	Sudden Cardiac Death	Varicose Veins	Venous Insufficiency
Mother														
Father														
Sister														
Brother														

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Pharmacy: \_\_\_\_\_ Pharmacy Address and Phone Number: \_\_\_\_\_

**Social History**

Do you drink alcoholic beverages? (circle one) YES NO

How many drinks per week? \_\_\_\_\_ glasses of wine  
 \_\_\_\_\_ cans of beer  
 \_\_\_\_\_ shots of liquor  
 \_\_\_\_\_ mixed drinks

Do you use illegal drugs/abuse prescription drugs? (circle one) YES NO  
 If yes which drugs? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever been a smoker? (choose from the below)  
 Never  
 Former; Quit date \_\_\_\_\_  
 Current smoker: Years smoked \_\_\_\_\_ Packs per day \_\_\_\_\_

Do you use smokeless tobacco? (choose from the below)  
 Never  
 Former; Quit date \_\_\_\_\_  
 Current user: Years used \_\_\_\_\_ Uses per day \_\_\_\_\_

If you smoke/use tobacco, are you ready to quit? (circle one) YES NO

Do you exercise regularly? (circle one) YES NO  
 Occasionally  
 Moderately  
 Heavy

Do you drink caffeine? (circle one) YES NO  
 Occasionally  
 Moderately  
 Heavy

**Allergies**

Have you had a reaction to X-Ray contrast dye? (circle one) YES NO

Are you allergic to iodine or shellfish? (circle one) YES NO

Are you allergic to any medications? (circle one) YES NO

If yes, please list medication names:

<u>Medication Name</u>	<u>Side Effect</u>

**Care Teams**

<u>Specialty</u>	<u>Doctor Name</u>	<u>Office Name</u>	<u>Office Number</u>
Primary Care			

**Patient Registration Form**  
(Please print or write legibly)

Last Name:		First Name:			MI:
Gender Identity:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Transgender M to F	<input type="checkbox"/> Transgender F to M	<input type="checkbox"/> Choose not to disclose
Date of Birth:	Social Security Number:				
Mailing Address:				Apt. #	
City:	State:		Zip Code:		
Please check the preferred primary phone number:					
<input type="checkbox"/> Home:	<input type="checkbox"/> Mobile:		<input type="checkbox"/> Work:		
Email:	Preferred Language:				
Marital Status:	Race:		Ethnicity:		
Emergency Contact Name:			Relationship:		
Primary Number:		Secondary Number:			
Employer:		Occupation:			
Address:				Suite #:	
City:	State:		Zip Code:		

**Insurance**

**Insurance card(s) or proof of insurance must be presented at time of service.**

<b>Primary Insurance:</b>		<b>Policy #:</b>	
Policy Holder's Name:		Policy Holder's DOB:	
<b>Secondary Insurance:</b>		<b>Policy #:</b>	
Policy Holder's Name:		Policy Holder's DOB:	
<b>Tertiary Insurance:</b>		<b>Policy #:</b>	
Policy Holder's Name:		Policy Holder's DOB:	

**Assignment and Authorization of Benefits for Patients with Insurance**

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Heart Endovascular and Rhythm of Texas, PLLC. I understand that I am financially responsible for all charges, co-payments, co-insurance, and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed, and benefits assigned.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**Financial Acknowledgement for Private Pay Patients or Patients without Insurance**

Patients without insurance coverage are expected to pay in full at the time services are rendered unless prior arrangements have been made with the practice.

I, the patient, acknowledge that I am financially responsible for all charges incurred during my visit.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**General Consent for Medical Evaluation and Treatment**

As a patient, you have the right to be informed about your condition and any recommended surgical, medical, or diagnostic procedures. This information is necessary for you to make an informed decision about whether to proceed with the suggested treatments or procedures, understanding the associated risks and hazards.

At this stage of your care, no specific treatment plan has been recommended. This consent form is intended to obtain your permission to perform the evaluation necessary to identify appropriate treatments and/or procedures for any identified condition(s). This consent will remain in effect until revoked in writing.

By signing below, you provide your consent for reasonable and necessary medical examinations, testing, and treatment. You acknowledge that:

1. This consent continues in nature, even after a specific diagnosis has been made and treatment recommended.
2. You consent to treatment at this office or any other satellite office under common ownership or contract.

You have the right to discuss the treatment plan with your physician, including the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. You have the right to discontinue services at any time.

I voluntarily request Heart Endovascular and Rhythm of Texas (H.E.A.R.T.), and other healthcare providers or their designees as deemed necessary, to perform reasonable and necessary medical examinations, testing, and treatment for the condition that has brought me to seek care at Heart Endovascular and Rhythm of Texas, PLLC. I understand that if additional testing or invasive procedures are recommended, I will be asked to read and sign additional consent forms before the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
**Relationship to Patient**

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HIPAA and Notice of of Privacy Practices Acknowledgement Consent**

\_\_\_\_\_ **(Patient/Representative Initials)** I hereby consent to the use and disclosure of my Protected Health Information (PHI) by Heart Endovascular and Rhythm of Texas (H.E.A.R.T.) for the purpose of providing treatment, obtaining payment for treatment, and conducting healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on my behalf to verify coverage or payment questions, or for any other purpose related to benefit payment.
- Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim, or to the appropriate state agency for payment of a Medicaid claim

This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment records, and discharge summaries.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors. These individuals and entities may share the patients’ health information with one another to accomplish goals that may include, but are not limited to:

- Improving the accuracy and increasing the availability of my health records
- Decreasing the time needed to access my information
- Aggregating and comparing my information for quality improvement purposes
- Other purposes as may be permitted by law

\_\_\_\_\_ **(Patient/Representative Initials)** I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases, including but not limited to bloodborne diseases such as HIV and AIDS.

\_\_\_\_\_ **(Patient/Representative Initials)** I understand that my PHI may include information both created and received by this practice, may be in the form of written or electronic records, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

\_\_\_\_\_ **(Patient/Representative Initials)** I understand that I have the right to revoke this consent in writing at any time, except to the extent that the practice has already taken action based on my prior consent. To revoke this consent, I must submit a written notice to:

**Heart Endovascular and Rhythm of Texas  
4310 James Casey St., 1A  
Austin TX, 78745**

\_\_\_\_\_ **(Patient/Representative Initials)** I understand that I have the right to request restrictions on how my PHI is used or disclosed for treatment, payment, or healthcare operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

\_\_\_\_\_ **(Patient/Representative Initials)** I acknowledge that I have received a copy of the Notice of Privacy Practices from H.E.A.R.T. I understand that this notice describes how my PHI may be used and disclosed and informs me of my rights regarding my PHI.

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Disclosures to Friends and/or Family Members**

\_\_\_\_\_ (Patient/Representative Initials) I give permission for my Protected Health Information (PHI) to be disclosed for the purposes of communicating results, findings, and care decisions to the following family members or individuals:

Name	Relationship	Contact Number

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Consent for Photographing or Other Recording for Security and/or Health Care Operations**

I \_\_\_\_\_ (Patient/Representative Initials) **do consent** or \_\_\_\_\_ (Patient/Representative Initials) **do not consent** to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes, and/or the practice/clinic’s health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to these images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without specific written authorization from me or my legal representative unless otherwise permitted or required by law.

**Patient Communication Consent Form**

We aim to maintain a strong connection with our patients. As a patient of our practice/clinic, you may be contacted via email, phone calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging. These communications will be used to confirm appointments, gather feedback on your experience with our healthcare team, and provide general health reminders/information.

By providing your email address, cellular telephone number, or text number below, you acknowledge that you may receive these communications from our practice/clinic. You can opt out of these communications at any time (see next page for details). Please note that while our practice/clinic does not charge for this service, standard text messaging rates or cellular telephone minutes may apply as per your wireless plan (contact your carrier for pricing plans and details).

**Authorization for Communication**

I authorize receiving text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information. My cell phone number is: \_\_\_\_\_.

I authorize receiving email messages for appointment reminders, general health reminders, feedback, and information. My email address is: \_\_\_\_\_.

**Decline Communication Options**

I decline to receive communication via text messages. \_\_\_\_\_ (Patient/Representative Initials)

I decline to receive communication via cellular telephone calls. \_\_\_\_\_ (Patient/Representative Initials)

I decline to receive communication via email messages. \_\_\_\_\_ (Patient/Representative Initials)

**Note:** This clinic uses an Electronic Health Record (EHR) system that will update all your demographic information, and consents based on the information you provide. This information will also be updated for your convenience across all our affiliated clinics that share an EHR system in which you have a relationship.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**Authorization for Release of Medical Information**

The form below will authorize the release of patient information TO Heart Endovascular and Rhythm of Texas (HEART) FROM another provider.

<b>Last Name:</b>		<b>First Name:</b>		<b>MI:</b>	
<b>Mailing Address:</b>				<b>Apt. #</b>	
<b>City:</b>		<b>State:</b>		<b>Zip Code:</b>	
<b>Home:</b>		<b>Mobile:</b>		<b>Work:</b>	

**Request Records from a provider (Be sure to complete this section to prevent delays in obtaining your records):**

<u>Doctor Name</u>	<u>Office Name</u>	<u>Office Number</u>	<u>Office Fax</u>

Please release the following information to Heart Endovascular and Rhythm of Texas (HEART) at:

Fax: (512) 215-8824  
 Email: [info@heartdoc.care](mailto:info@heartdoc.care)

Please circle all that apply:

<b>Entire Record</b>	<b>Immunization Records</b>	<b>Laboratory Reports</b>	<b>Radiology/Imaging Reports</b>
<b>Consultation</b>	<b>Progress Notes</b>	<b>Most Recent History and Physical</b>	<b>Other:</b>

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

**Description or the purpose of the use and/or disclosure (please circle all that apply):**

<b>Continuing Care</b>	<b>Second Opinion</b>	<b>Social Security/Disability</b>	<b>Personal Use</b>
<b>Consultation/Referral</b>	<b>Insurance</b>	<b>Legal Purposes</b>	<b>Other (please describe):</b>

I understand that this authorization is voluntary, and I may refuse to sign this authorization, I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand Heart Endovascular and Rhythm of Texas has fees for the type of records provided. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.

**This authorization will be in effect until \_\_\_\_\_ (date of event).**

I understand I may revoke this authorization at any time by notifying Heart Endovascular and Rhythm of Texas. I understand that if I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ <b>Signature of Patient or Personal Representative</b>	_____ <b>Date</b>
_____ <b>Printed Name of Patient or Personal Representative</b>	_____ <b>Relationship to Patient</b>

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Patient Balance Policy**

All visits must be paid at the time of service, or a credit card is to be placed on file within the patient’s account.

**Copays:** Patients are required to pay copay at the time of check-in.

**Deductibles:** Allowable amount must be paid at the time of service. If a patient believes they have met their deductible, we will bill insurance and invoice the patient. The patient will be required to pay the full amount upon receiving the invoice or at their next visit.

**Self-Pay/Private Pay:** Patients are required to pay for their office visit at the time-of-service practice’s fee schedule. We encourage patients to keep a card on file to cover any additional services that may be incurred during the visit.

**Card on file/Automatic Payments/Refunds:** Automatic payment allows HEART to charge your credit card for any out-of-pocket costs not covered by insurance for services provided by HEART. Your credit card will be charged upon review of the final explanation of benefits from each applicable insurance company for services billed, or at the time of service if not submitting to insurance. You will receive receipts detailing the amount charged and will be notified prior to each transaction. Please contact us immediately with any questions or concerns. The limit per charge is \$200 per visit for all office services provided, with a maximum annual limit of \$1500. If a refund is required, we will issue it automatically to the same card.

**Unpaid Balances**

- Balances less than \$200 must be paid at time of service
- Balances \$200 - \$500 are permitted a payment plan of 3 months.
- Balances \$500 - \$1,000 are permitted a payment plan of 6 months
- Balances over \$1,000 will require Coordinator overview. Coordinator is to approve any payment plans discussed over \$1,000.

**Note:** Payment for the current service is to be made in addition to any outstanding balance. For example, if the visit cost is an \$85 deductible fee and a \$75 outstanding balance, the full amount must be paid at the time of service, as the total is less than \$200. If payment for the visit and/or outstanding balances is refused, patients must remain at the clinic to speak with the coordinator. Otherwise, a block will be placed on the account, and they will be unable to book future appointments.

**Same Day Cancellation/No Show Policy**

When you schedule an appointment with H.E.A.R.T. we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. Please see our Same Day Cancellation, No Show Policy below:

- Effective immediately, all patients who fail to show or cancel/reschedule an appointment and has not contacted our office with at least a 24 hours’ notice will be considered a **No- Show** and will be charged:
  - Established patient follow up visit: \$25
  - New Patient and Imaging: \$50
  - Nuclear and PET: \$200
- If a third no-show or cancellation within 24 hours’ notice should occur, the patient will be restricted to same day scheduling only.
- Any new patient who fails to show for their visit two times consecutively will not be rescheduled.
- The fee is charged to the patient and not the insurance company and is due at the time of the patient’s next office visit.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office directly, 8:00 am to 5:00 pm, Monday through Friday at 512-504-7411.

By signing below, I acknowledge receipt of these policies. I have read and fully understand the Patient Balance and Same-day Cancellation/No-Show Policy, and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
**Relationship to Patient**