St David's Heart & Vascular

MEDICAL HISTORY QUESTIONNAIRE

IF IT HAS BEEN THREE OR MORE YEARS SINCE YOUR LAST VISIT, COMPLETE THE ENTIRE FORM
IF LESS THAN THREE YEARS, PLEASE UPDATE AREAS THAT HAVE CHANGED SINCE THE LAST VISIT

Patient Name_____ Appt. Date_____ Date of Birth_____ Age_____

Primary Care Doctor_____

DO YOU HAVE A LIVING WILL OR A MEDICAL POWER OF ATTORNEY? ○ YES ○ NO
HAVE YOU HAD THIS SEASON'S FLU IMMUNIZATION ○ YES ○ NO **DATE**_____
HAVE YOU HAD YOUR PNEUMONIA IMMUNIZATION ○ YES ○ NO **DATE**_____

Please check anything you have been diagnosed with:

PAST MEDICAL HISTORY

- ○ Aortic aneurysm
- ○ A-Fib
- ○ Anemia
- ○ Angina
- ○ Arrhythmia
- ○ Asthma
- ○ Cancer
- ○ Cardiomyopathy
- ○ Carotid disease
- ○ Heart Failure
- ○ Clotting disorder
- ○ Coronary artery disease
- ○ Diabetes
- ○ Heart murmur
- ○ High cholesterol
- ○ High blood pressure
- ○ Kidney disease
- ○ Heart attack
- ○ Peripheral arterial disease
- ○ Sleep apnea
- ○ Stroke/TIA
- ○ Syncope (fainting)
- ○ Thyroid disease
- ○ Varicose/Spider Veins

OTHER MEDICAL HISTORY

- ○ Anxiety
- ○ Arthritis
- ○ Blood clots in veins/lungs
- ○ COPD/Emphysema
- ○ Depression
- ○ Easy bruising/bleeding
- ○ HIV/AIDS
- ○ Liver problems/Hepatitis
- ○ Menopause
- ○ _____
- ○ Phlebitis/Swelling
- ○ Rheumatic fever
- ○ Stomach/Intestinal ulcers
- ○ Tuberculosis
- ○ _____

PAST CARDIAC SURGERIES

- ○ AAA repair
- ○ Cardiac ablation
- ○ ASD repair
- ○ Coronary bypass
- ○ Cardiac catheterization
- ○ Cardioversion
- ○ Carotid stent
- ○ Coronary stent
- ○ ICD
- ○ _____
- ○ LARIAT
- ○ Pacemaker
- ○ Peripheral stent
- ○ Valve repair/replacement
- ○ _____

OTHER SURGICAL HISTORY

- ○ Appendectomy
- ○ Carpel tunnel release
- ○ Cataract
- ○ C-section
- ○ _____
- ○ Fracture repair
- ○ Gall bladder
- ○ Hip replacement
- ○ Hysterectomy
- ○ _____
- ○ Knee replacement
- ○ Knee surgery
- ○ Tonsils/Adenoids
- ○ Vasectomy/Tubal ligation
- ○ _____

FAMILY HISTORY

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														
Mat Aunt														
Mat Uncle														
Pat Aunt														
Pat Uncle														
MGM														
MGF														
PGM														
PGF														

☐ Adopted ☐ Family History Unknown

SOCIAL HISTORY

Do you drink alcoholic beverages? ○ 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? ○ Yes ○ No If yes which drugs? _____
How often? _____

Have you ever been a smoker? ○ Never ○ Former, quit date _____ ○ Current smoker
Years smoked _____ Packs per day _____

Do you use smokeless tobacco? ○ Never ○ Former, quit date _____ ○ Current user
Years used _____ Uses per day _____

If you smoke/use tobacco, are you ready to quit? ○ Yes ○ No

Do you exercise regularly? ○ Yes ○ No
Do you drink caffeine? ○ Yes ○ No

ALLERGIES

Have you had a reaction to X-Ray contrast dye? ○ Yes ○ No
Are you allergic to iodine or shellfish? ○ Yes ○ No
Are you allergic to any medications? ○ Yes ○ No
If yes, please list medication names_____

St David's Heart & Vascular

Patient Registration Form

(Please print or write legibly)

Last Name:_____ First:_____ MI:_____

Gender Identity: ◯ Female ◯ Male ◯ Transgender Female to Male ◯ Transgender Male to Female ◯ Choose not to disclose

Date of Birth:_____ Social Security:_____

Mailing Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____

Please check the preferred primary phone number:

☐ Home Phone: (_____)-_____ ☐ Work Phone: (_____)-_____

☐ Mobile Phone: (_____)-_____ Email:_____

Preferred Language:_____ Marital Status:_____ Race/Ethnicity:_____

Emergency Contact Person:_____ Relationship:_____

Primary Number: (_____)-_____ Secondary Number: (_____)-_____

Primary Care Physician:_____ Referring Physician:_____

Employer's Name:_____ Occupation:_____

Employer's Mailing Address:_____ Suite #:_____

City:_____ State:_____ Zip:_____

Insurance

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

Primary Insurance:_____ Policy #_____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____/_____/_____

Secondary Insurance:_____ Policy #_____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____/_____/_____

Tertiary Insurance:_____ Policy #_____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____/_____/_____

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 St. David's Heart & Vascular, 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**

Financial acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative **Date**

St David's Heart & Vascular

PATIENT CONSENT FORM

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

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

I voluntarily request a St. David's Heart and Vascular physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at St. David's Heart & Vascular, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to 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**
Printed Name of Witnessing Employee	**Employee Job Title**
Signature of Witnessing Employee	**Date**

Financial and Insurance Policy

Thank you for choosing *St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia* for your healthcare services.

Insurance coverage is considered by St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia as an agreement between the patient, the insurance company and the employer, where applicable. St. David's Cardiology d.b.a. Texas Cardiac Arrhythmia is not a party to that agreement and as a result is not bound by any of the covenants, limitations, or restrictions of that policy.

As a service to our patients, we will file insurance claims for the services provided. Itemized bills will be provided to you for those services upon request. The filing of insurance does not release the patient from responsibility of incurred charges for services which have been provided.

All fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made in advance.

If you have health insurance, you are responsible to:

- Verify with your insurance carrier that services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.
- Obtain any authorizations or referrals required by your insurance carrier.
- Pay our office for any deductible, co-payment or non-covered charges.

Unless specific arrangements have been made in advance for an extension of time, charges for services not covered by insurance are due upon receipt of a patient statement. Patients without sufficient financial resources to pay may be eligible for Patient Assistance. If you have special needs, please contact the billing office at 512-206-4300 option 1 for assistance.

If you do not have health insurance coverage:

- Payment for the office visit and all diagnostic services is expected prior to service provided.
- You will receive an estimate of proposed surgical charges and will be expected to contact our business office at 512-206-4300 option 1 to make suitable financial arrangements prior to your procedure.
- If you were treated by one of our physicians under emergency circumstances, please contact the billing office at 512-206-4300 option 1 to discuss your financial arrangements as soon as possible. .

Patients without health insurance are eligible for a 35% discount off the standard fee when paid in full at time of service.

Finance plans are available to assist patients with deductibles, co-insurance, and non-covered services. These plans offer flexible financing options to include no interest financing, low minimum monthly payment options and an instant approval process for qualified applicants. For additional information on financing options, please contact our billing office at 512-206-4300 option 1.

Statements showing the status of your account are mailed monthly. St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia is prepared to counsel any patient experiencing difficulty in meeting payment obligations. If you are unable to make payment when due, please contact the billing office at 512-206-4300 option 1.

Accounts not paid within 45 days of statement receipt are subject to placement with an outside collection agency.

In the event we receive a returned check, a fee of $35.00 will be charged to your account and payment in full due upon receipt of your statement.

Please acknowledge your understanding and acceptance of St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia Financial and Insurance Policy by signing below.

_____ _____

Patient / Guardian Signature Date

_____ _____

Patient Printed Name Birth Date

St. David's Heart & Vascular dba Texas Cardiac Arrhythmia

PATIENT NAME_____ **DATE OF BIRTH**_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ **(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____ **(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ **(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** any insurance or other third-party benefits available for health care services provided to me. I understand **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ **(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** by the Medicare or Medicaid program.

5. _____ **(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **St. David's Heart & Vascular dba Texas Cardiac Arrhythmia** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ **(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____ Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney Legal
Guardian_____	Other (please specify)_____

St David's Heart & Vascular

Section A: This section must be completed for all Authorizations (Texas)			
Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN** (optional)**:**
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:**		
	Address 2:	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

If this authorization is for disclosure of genetic information, please describe: _____

I understand that:

I may refuse to sign this authorization and that it is strictly voluntary.

My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.

I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Please sign this form in the event we need to request records on your behalf from any other physician or hospital. By signing today, this will expidite the medical release process in the future. Thank you.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

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

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the 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 a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order 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 and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be 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; and such other purposes as may be permitted by law. 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, blood borne diseases, such as HIV and AIDS.

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

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic]

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.