

MRN: _____ (office use only)

PRIMARY INSURANCE: _____

PATIENT ID: _____ GROUP : _____

INSURED'S NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ SOCIAL SECURITY: _____

INSURED'S EMPLOYER: _____

SECONDARY INSURANCE: _____

PATIENT ID: _____ GROUP: _____

INSURED'S NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ SOCIAL SECURITY: _____

INSURED'S EMPLOYER: _____

TERTIARY INSURANCE: _____

PATIENT ID: _____ GROUP: _____

INSURED'S NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ SOCIAL SECURITY: _____

INSURED'S EMPLOYER: _____

Assignment and Release of Information:

I, the undersigned, certify that I have insurance coverage with the above insurance company and assign directly to MEMORIAL CARDIOLOGY ASSOCIATES, PA/KATY PREVENTIVE CARDIOLOGY all insurance benefits if any, otherwise payable to me for services rendered. I understand I am fully responsible for all charges whether paid or not by the insurance company. I hereby authorize MEMORIAL CARDIOLOGY ASSOCIATES, PA to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.

Notice of Privacy Practices and Consent to Use and to Disclose Protected Health Information:

Your protected health information will be used by MEMORIAL CARDIOLOGY ASSOCIATES, PA/KATY PREVENTIVE CARDIOLOGY or disclosed to others for the purposes of treatment, obtaining payment, or supporting day-to-day healthcare operations of the practice. MEMORIAL CARDIOLOGY ASSOCIATES, PA/KATY PREVENTIVE CARDIOLOGY reserves the right to modify the privacy practices outlined in the privacy notice. Notification will be served upon a change. I have reviewed the brochure "Notice of Privacy Policies and Practices" and give my permission to MEMORIAL CARDIOLOGY ASSOCIATES, PA/KATY PREVENTIVE CARDIOLOGY to use and disclose my health information in accordance with this consent and the notice provided.

PATIENT'S SIGNATURE/ RESPONSIBLE PARTY'S SIGNATURE

DATE

PATIENT CONSENT FOR USE OF EMAIL COMMUNICATIONS

To better serve our patients, this office has established a web portal for some forms of communication. For routine matters that do not require immediate response, please feel free to register on our website and contact us through our web portal. The turnaround time for routine patient communications is **24 business hours**. The service provider may delay message delivery. **Please remember that this form of communication is not appropriate for use in an emergency. Should you require urgent or immediate attention, this medium is not appropriate.**

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to a physician, MEMORIAL CARDIOLOGY ASSOCIATES, PA/KATY PREVENTIVE CARDIOLOGY designated staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email and web portal.

Patient's Name: _____ Date of Birth: _____

Patient's Signature: _____ Date: _____

MRN: _____ (office use only)

FINANCIAL POLICY

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. MEMORIAL CARDIOLOGY ASSOCIATES, PA/ KATY PREVENTIVE CARDIOLOGY accepts cash, personal check (in-state only), VISA, MasterCard and American Express. There is a service charge of \$25.00 for returned checks.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments. Please check with the front office staff regarding a payment plan/financial arrangements.

INSURANCE:

It is your responsibility to know your insurance coverage and benefits. It is your contract obligation with your insurance company to pay your deductible and co-payments. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. You are responsible for all unpaid charges.

If you need assistance or have questions, please contact the Billing Department between 8:00 am-4:00 p.m., Monday through Thursday and 8am- 3pm on Friday at (713) 464-6006 option 5.

MANAGED CARE:

If you are enrolled in managed care insurance plan i.e. HMO, we must receive a referral from your Primary Care Provider's office before seeing you. It is your responsibility to obtain the referral prior to scheduling an appointment with our office.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Any missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge \$50.00 for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

FORMS:

Patients needing forms to be completed by the physician must allow the physician 72 hours to complete and sign. Our office reserves the right to charge up to \$75.00 for a form to be completed by the physician.

MEDICAL RECORDS:

Patients requesting medical records must sign a release of medical records and allow 15 days for the records to be copied. There is a medical records fee of \$25.00 for the first 20 pages and \$ 0.50 cents each additional page or a CD up to 500 pages for \$25.

PRESCRIPTION REWRITE:

Prescriptions are generally written in quantity to last until the patient's next scheduled appointment. If it becomes necessary for our office to call in a refill for a prescription due to a patient's failure to keep an appointment, a charge of \$10.00 will be charged to you. There will be a charge of \$10.00 for any triplicate prescription that must be rewritten due to lost or expiration.

I, _____ have read and understand the Financial Policy of MEMORIAL CARDIOLOGY ASSOCIATES, PA/ KATY PREVENTIVE CARDIOLOGY .

Patient's Signature

Date

**MEMORIAL CARDIOLOGY ASSOCIATES, PA
KATY PREVENTIVE CARDIOLOGY**

IMPORTANT NOTIFICATION

In order to provide better healthcare for you, our office enforces a strict “**NO SHOW**” policy.

For your convenience our staff spends a considerable amount of time preparing your chart and verifying insurances a day ahead of the scheduled appointment. If you in turn do not show up for this scheduled appointment this creates hardship for a potential patient who could have been seen in that appointment time slot. It is also a loss of revenue to the practice and a waste of our staff’s time.

In order to help you keep your scheduled appointment our staff gives you a reminder call a day prior to your appointment. We therefore expect that you immediately notify us of any telephone or address changes.

To reschedule or cancel an appointment, we expect to be notified at least one day prior to your appointment. If you have **3** consecutive accumulative “**NO SHOWS**” within 6 months, we reserve the right to charge you \$50.00. In the event that you accumulate more than 6 consecutive no shows within a 6 months period, you may receive a dismissal letter from our office giving you a 30 day period to find another healthcare provider.

____ I have read and understand this notice in its entirety.

____ This notice has been read to me and I understand it.

Patient’s Name Printed

Date

Patient’s Signature

Witness

MRN: _____ (office use only)

**MEMORIAL CARDIOLOGY ASSOCIATES, PA
KATY PREVENTIVE CARDIOLOGY**

HIPAA Privacy Act Patient Consent Form

The Health Insurance Portability and Protection Act, HIPAA, requires that all medical providers, Insurance Companies and others, put in place controls to ensure that your personal medial information is safe.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent or as required by law.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. Copies are available.

I have received a copy of Memorail Cardiology Associates, PA/Katy Preventive Cardiology HIPAA compliance literature.

Patient's Name/ Responsible Party's Name	Signature	Date
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Authorization to Release Information

I authorize the release of medical records to and from another physician said assignee who is consulting in my care to Philip Berman, MD, Randall Morris, MD, Stuart Jacobson, MD, Michael Mitschke, MD, and/or Omar Awar, MD to assist in continuity of my care.

I authorize this office to speak to the listed individual below regarding my appointment times, rescheduling of appointments, insurance/billing information, results of testing and medical conditions/care.

1) Name: _____ Relationship to Patient: _____

2) Name: _____ Relationship to Patient: _____

3) Name: _____ Relationship to Patient: _____

I authorize this office to leave messages on my voicemail regarding appointments, insurance information and to leave messages to call office to discuss medical issues or concerns.

You have the right to revoke this consent at anytime, except where disclosures have already been made by your prior consent. I permit a copy of this authorization to be used in place of the original.

Patient's Name/ Responsible Party	Signature	Date
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**MEMORIAL CARDIOLOGY ASSOCIATES, PA
KATY PREVENTIVE CARDIOLOGY**

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received and read the following

____ Patient consent for use and disclosure of protected health information

____ Financial and Billing Policies

From MEMORIAL CARDIOLOGY ASSOCIATES, PA/ KATY PREVENTIVE CARDIOLOGY

1) Please list the family member or other persons, if any, whom we MAY NOT inform about your general medical condition (including treatment, payment and health operations).

2) Can confidential messages (i.e. appointment reminders and financial matters) be left on your telephone answering machine or voicemail?

Yes _____ No _____

EMAIL: _____
For appointment reminders and possibly billing issues

BEST PHONE NUMBER TO CONTACT YOU BY: _____

My signature below confirmas that this has been provided to me.

Signature of Patient Date

Patient's Name MRN (office use only)

Signature of Legal representative or Guardian (If patient is a minor) Date

Witness Date

**MEMORIAL CARDIOLOGY ASSOCIATES, PA
KATY PREVENTIVE CARDIOLOGY**

Dear Patients:

Due to many changes occurring in the healthcare system related to the Affordable Healthcare Act (Obamacare), the federal sequester, and CMS reductions in the physician payment. We are no longer able to extend credit indefinitely for services rendered nor are we able to should the burden of billing and collections for small balances.

As a consequence, all patients of MEMORIAL CARDIOLOGY ASSOCIATES, PA/ KATY PREVENTIVE CARDIOLOGY are required to place a credit card or debit card or cash deposit on file with authorization for charges up to \$100.00.

For patients with insurance obtained via Healthcare.gov your signature will grant authorization to charge your credit card for the full balance for services rendered should your policy be found to have been terminated for non payment of premiums during the 90 days grace period granted by the Affordable Care Act.

A valid email address to which receipts may be sent is also required.

Patient's Name	Date of Birth	MRN
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Email Address

Credit Card Number	Expiration
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CVS Code	Signature
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**MEMORIAL CARDIOLOGY ASSOCIATES, PA
KATY PREVENTIVE CARDIOLOGY**

Name: _____ Age: _____ Date: _____

Why have you come to the Cardiologist today?

Are you having any chest pain? Yes / No
If yes, please describe location of pain, duration, frequency:

Does the pain cause any of the following?(please circle one)

Shortness of breath / Nausea / Vomiting / Seating / Palpitations

Is the pain related to exertion or meals? Yes / No

Past Medical History

Have you ever been diagnosed with high blood pressure? Yes / No

How long?

Have you been diagnosed with diabetes? Yes / No

How long?

Have you been diagnosed with high cholesterol or triglycerides? Yes / No

Are you taking cholesterol or triglyceride lowering medications? Yes / No

Have you been diagnosed with Asthma / COPD/ Emphysema? (please circle)

Do you suffer from Sleep Apnea? Yes / No

Have you ever had a Stroke? Yes / No

Have you ever had Rheumatic Fever? Yes / No

Have you ever had a stomach ulcer that bleeds? Yes / No

Have you ever had a blood clot in your legs or lungs? Yes / No

Have you ever been diagnosed with any type of heart disease? Yes / No

If yes, please describe: (heart attack, valve disease, stents, murmur)

MRN: _____

Please list any surgical procedures and dates:

Please list all medications, dosages, and frequency you are using, including supplements:

Please list any medication allergies:

Are you allergic to iodine or shellfish? (please circle) Yes / No

Do you smoke? Yes / No

If yes, how many packs per day and how long?

If you are a former smoker; how much did you smoke for how long and when did you quit?

Do you drink alcohol? Yes / No

If yes, how much per week?

Any other pertinent personal medical history? (please list)

EX: (autoimmune disease {lupus, Rheumatoid Arthritis}, thyroid disease, kidney disease, gout)

Family History - Blood Relatives

(please list who and ages)

MRN: _____

Has any one in your family ever been dignosed with heart disease? Yes / No
(Heart attack, stents, valve disease, bypass surgery, pacemaker, sudden cardiac death, irregular rhythm)

Have anyone in your family ever had a stroke? Yes / No

Has anyone in your family been diagnosed with high blood pressure? Yes / No

Has anyone in your family been diagnosed with high cholesterol? Yes / No

Has anyone in your family been diagnosed with cancer? Yes / No

Has anyone in your family ever had blood clots in their legs or lungs? Yes / No

Has anyone in your family been diagnosed with diabetes? Yes / No

**MEMORIAL CARDIOLOGY ASSOCIATES, PA
KATY PREVENTIVE CARDIOLOGY**

Notice of Privacy Practices

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

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- **Treatment:** We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise. We may disclose your information to private research companies for the purpose of studies of vaccines and/or treatments.
- **Payment:** We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- **Health operations:** We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must

have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.

- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to opt out of private research for studies relating to vaccines and/or treatments.
- You have the right to opt out of EPrescribing, electronic submission of your prescriptions.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer

Phone number: (713) 464-6006

Office for Civil Rights

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on (date) 11/1988 and revised 08/01/2013.