CYPRESS HEART & VASCULAR CENTER

21212 NORTHWEST FREEWAY, POB II, SUITE 505
CYPRESS, TX 77429
PHONE: 832-688-8400 / FAX: 832-688-8430

PATIENT DEMOGRAPHICS SHEET

***Please make sure Names and Numbers are correct. We require all the information for New Patients and we update every year. This allows us to better serve you when you need Medication Refills or samples, Records Transferred, Appointment Reminders and/or any medical questions.

PATIENT FULL NAME: _____
(Name as show on Insurance Card) First Name Initial Last Name Suffix

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

ADDRESS: _____
Street City State Zip Code

HOME PHONE #: _____ **CELL PHONE #:** _____

WORK #: _____ **E-MAIL:** _____

In case of an emergency please provide a contact name, phone number and relation to patient.

_____

LOCAL PHARMACY NAME AND PHONE #: _____

MAIL SERVICE PHAMACY NAME: _____

****PRIMARY INSURANCE NAME:** _____

MEMBER/SUBSCRIBER ID #: _____ **GROUP #:** _____

****SECONDARY INSURANCE NAME:** _____ **MEMBER/SUBSCRIBER ID #:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE #:** _____

REFERRING PHYSICIAN: _____ **PHONE #:** _____

I hereby, with my respective signature, certify and confirm the above information to be true.

_____ _____
Patient / Legal Guardian Signature Date

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MEDICAL HISTORY FORM

PATIENT NAME: _____ **DOB:**_____

CURRENT MEDICATIONS AND DOSAGES:

_____

_____

_____

PAST MEDICAL HISTORY:

_____

_____

_____

ALLERGIES TO MEDICATIONS: _____

PAST SURGICAL HISTORY:

_____

_____

FAMILY HISTORY:

_____

_____

_____

SOCIAL HISTORY:

ALCOHOL: NO/YES. IF YES, DRINK PER WEEK: _____

TOBACCO: NO/YES. IF YES, CIGARETTES PER DAY: _____

DRUG USE: NO/YES. IF YES, TYPE OF DRUG[S] USED: _____

OCCUPATION: _____

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RELEASE OF MEDICAL INFORMATION

We will need to access your private healthcare information for the purpose of treatment, payment, and operations. In using this information our office will comply with state and federal laws pertaining to your privacy rights, including the HIPPA act. We will disclose your information only when sharing the information for the purpose of treatment, payment, or operations. This information may be shared with but is not limited to your primary care physician[s], referring physician [s] and specialist [s] who will be involved in your medical care or treatment.

This includes and is not limited to, Labs, Testing and Imaging reports, Progress Notes and Entire Medical Records.

In order to obtain medical records from another physician or medical institution, or to provide medical records as stated above please sign below in acknowledgment of your consent.

With my signature I authorize the request and release of my medical records To and From Cypress Heart & Vascular Center.

_____

Patient Signature

_____ _____

Patient Name (Print) **Date of Birth**

Dear Patient,

We believe that patients and your caregivers should have easy access to your medical information, no matter where you receive care. That is why we are participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that you receive optimal care.

What is CommonWell?
A free, secure service offered by your doctor, so your health information can be available your doctors regardless of where you have received care.

How do we use the health information we share through CommonWell?

- **Better coordinate your care across different doctors –** We will provide and request to receive your information where and when it is needed for your healthcare provider to deliver the care you need.
- **Support better care decision-making –** With timely access to information from other healthcare providers you have seen, your doctors may be able to make better decisions about your health.
- **Deliver care more promptly and efficiently –** With less time wasted on tracking down your test results and other health information, your healthcare providers can treat you more efficiently and spend less time on paperwork and more time on your care.
- **Securely and confidentially –** Your Protected Health Information (PHI) will always be confidential and used to inform the CommonWell participating healthcare providers. We will not use your PHI for discriminatory purposes of any kind or to deny medical treatment. This information will only be used to help improve your care, and will not be shared without your permission or unless it is required by law. Only healthcare staff directly involved in you care will have access to you medical information shared through CommonWell.

_____ I want to participate in the CommonWell/Care Quality Program

With my signature below I authorize Cypress Heart & Vascular Center to disclose and obtain information related to my visit to the CommonWell network.

_____ I choose **NOT** to participate in the CommonWell/Care Quality Program

_____ _____
Patient Name (Print) Date

_____
Patient Signature

CommonWell Health Alliance
The CommonWell services are provded by the CommonWell Health Alliance trade association. We are devoted to the notion that patient data should be safely, securely, and immediately to patients and doctors regardless of where care occurs to deliver better care. We are committed to fostering standards that make this possible, and in having health information technology companies build these capabilities into their systems – the results: higher quality, more timely, more cost-effective care that delivers better health outcomes. Some of the participating vendors are Allscripts, athenahealth, Cerner, CPSI, eClinicalWorks, Greenway, McKensson, and Sunquest. Please visit https://www.commonwellalliance.org/connect-to-the-network/commonwell-connected-products/ for a complete list of connected vendors

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FINANCIAL POLICY

We will collect co-payments, deductibles, and co-insurances prior to services being rendered. This applies to all patients including those with health insurance plans, Medicare, and/or Medicaid. If a balance remains after an office visit, you will be asked to kindly make a payment in a subsequent visit, or we may bill you for the remaining balance.

In order to schedule a procedure, pre-payment is required and is based on your medical deductible and/or co-insurance. This is an estimate based on a contracted rate between the physician and the insurance company. Please be advised that the charges are only an estimate.

Collections of co-pay and/or co-insurance are mandatory prior to seeing the physician. Our office posts the co-insurance amounts based on an individual's explanation of benefits (EOB). If you have any questions regarding your insurance rates, please contact your insurance company as they will provide an accurate explanation. If you are unable to make payments on your remaining balance within 30 days, please contact our billing staff to make alternate arrangements. If payments are not received in a timely manner, your account will be subject to collections.

Please be aware that whether you have medical insurance or do not have medical insurance, you are ultimately financially responsible.

****Please be advised that our office has a 24 hour cancellation policy. Otherwise a no show fee will apply****

_____ _____

Patient Signature **Date**

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NOTICE OF PRIVACY PRACTICES

Effective date: January 03, 2011

OUR COMMITMENT TO YOUR POLICY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI), as it related to the HIPPA (Health Insurance Portability and Accountability Act). We will create records regarding you and the treatment we provide you. We are required by law to maintain the confidentiality of your IIHI. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice. We realize that these laws are complicated, but we must provide you how we may use and disclose your IIHI, your privacy rights in your IIHI and our obligation concerning the use and disclosure of your IIHI.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe the different ways in which we may use and disclose your IIHI. We do not need any type of authorization from you for the following uses and disclosures. 1. Treatment: We may use or disclose your IIHI to other healthcare provider providing treatment to you. 2. Payment: We may use and disclose your IIHI to obtain payment for services we provide to you. 3. Health Care Operations: We may use and disclose your IIHI to operate our business. 4. Appointment reminders: We may use and disclose your IIHI to contact you and remind you of an appointment. 5. Treatment options: We may use and disclose your IIHI to inform you of potential treatment options or alternatives. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you. 6. Release of Information to Family/Friends: We may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. 6. Disclosures required by law: We will use and disclose your IIHI when we are required to do so federal, state or local law.

USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information. 1. Public health risks: We may disclose your IIHI to public health authorities that are authorized by law to collect such information. 2. Serious threats to health or safety: We may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. 2. Research: We may use and disclose your IIHI for research purposes unless and Internal Review Board or Privacy Board has determined that your authorization is required. 3. Workers' Compensation: We may release your IIHI for workers' compensation and similar programs.

PATIENT RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you. 1. Confidential Communications: You have the right to request that our practice communicate with you about your health issues in a particular manner or in a particular location. 2. Restrictions: You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payments or health care operations. 3. Access: You may request access to your medical file and records maintained by us. Requests must be made in writing or email. If you request copies by fax or email, there will be no charge. However, if mailed copies are sent to you, we will charge for postage and handling. 4. Right to a paper copy of this notice. 5. Complaints: If you believe that your privacy rights have been violated, you may file a complaint, in writing with our practice or with the OCR/Secretary of the Department of Health and Human Services, contact number 877-696-6775. To file a complaint in our practice please send an email to our privacy officer. 6. Authorizations: Our practice will obtain in writing authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to use regarding the use and disclosure of your IIHI may be revoked at any time in writing. 7. Accounting of Disclosures: You have the right to receive an accounting of disclosures of your IIHI. 8. Amendments: You have the right to take exception to information in your records and request corrections.

Privacy Officer and Office manager: Gida Zatari. Contact Number: 832-688-8400.

PLEASE SIGN IN ACKNOWLEGEMENT THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE

_____ _____

Patient Signature **Date**

HIPPA Privacy Authorization Form

Authorization for use or Disclosure of Protected Health Information
(Required by the health Insurance Portability and Accountability Act – 45 CFR Parts 1650 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ From (date) _____ To (date) _____ OR
   b. ☐ All past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one)
   a. ☐ My complete health record (including records relation to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ My complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____

4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

5. This medical information may be used by the persons I authorize to receive this information for my treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand revocation is not effective to the extent that any person or entity as already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient Signature Date