TEXAS CARDIAC ARRHYTHMIA

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Name:_____

Social Security Number: _____ - _____- _____ DOB: _____

Home Address:_____

City, State, Zip:_____

Home: _____ Cell: _____

Work: _____

Email Address: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ White ☐ Hispanic ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self

Check here if address and telephone information is same as patient ☐

Responsible party name:_____Date of birth: MM/DD/YYYY:_____

Social Security Number: _____ - _____ - _____ Sex: ☐ Female ☐ Male

Phone number: _____

Home Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name:_____Phone number: _____

Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____

Home Address:_____City, State: __ ZIP: _____

Home phone: _____ Work phone: _____Ext _____

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Health History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?:_____

Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____

Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you or have you used the following in the last three months?

☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Crack ☐ Methamphetamine

Are you allergic to any medications? Yes or No(If yes, please list.)_____

Current Medications/ Dosage	Frequency

Previous Surgery	Date

Have you ever had any of the following? Circle all that apply: Asthma/ Stomach Problems/ Bladder problems/ Jaundice-Liver/ Gout/ Alcoholism/ Kidney Disease/ Prostate/ Skin Disease/ Joint Disease/ Stroke/ Epilepsy-Seizures/ Depression-Anxiety/ Thyroid/ Blood Clot/ High Blood Pressure/ Tuberculosis/ Diabetes/ Cancer/ Lung Disease/ Heart Disease/ Psychiatric Disorder

Do any of these conditions run in your family? Circle all that apply:

Alcoholism/ Addiction/ Joint Disease/ Stroke/ Blood Clots/ Diabetes/ Psychiatric Disorder/ Heart Disease

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Primary care physician information:

Name: _____ Phone number: _____

Address: _____

Primary Cardiologist Information:

Name: _____ Phone Number: _____

Address:_____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

How did you hear about us?

Circle any that apply: Webs/ Family/Friend/ Internet Search:

Former or current patient (please provide name so we can thank them!) _____

Physician (please specify): _____

Other Healthcare facility (please specify): _____

Insurance Network (please specify):_____

Other (specify): _____

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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).

*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. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

*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. I voluntarily request a 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 this practice. 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: _____

Patient HIPAA Acknowledgment and Consent Form

Notice of Privacy Practice/clinics.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, 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 practice/clinic's Notice of Privacy Practice/clinics.

Patient Consent for Financial Communications

Financial Agreement

——I acknowledge, that as a courtesy, 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 there is a fee for returned checks.

Third Party Collection. I acknowledge TEXAS CARDIAC ARRHYTHMIA may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to TEXAS CARDIAC ARRHYTHMIA any insurance or other third-party benefits available for health care services provided to me. I understand TEXAS CARDIAC ARRHYTHMIA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to 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.

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 TEXAS CARDIAC ARRHYTHMIA by the Medicare or Medicaid program.

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

-I consent ____ (Patient/Representative Initials) 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 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.

-OR-

-I do not consent ____ (Patient/Representative Initials) 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).

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

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page).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).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.
I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email is** _____.

-O-

I **decline** _____ (Patient/ Representative Initials) to receive communication via text.
I **decline** _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.
I **decline** _____ (Patient/ Representative Initials) to receive communication via email.

Note: *This clinic 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 clinics that share an electronic health record in which you have a relationship.*

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call.

In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**..*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call.***
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Consent to Telephone Calls for Financial Communications. I agree that, in order for 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 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 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.

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

Patient/patient representative signature: _____ **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/Other (please specify): _____

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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.

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

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed): _____

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.

TEXAS CARDIAC ARRHYTHMIA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO TEXAS CARDIAC ARRHYTHMIA

FACILITY/DOCTOR RECORDS REQUESTED FROM:_____

PATIENT NAME:_____

DATE OF BIRTH: _____

SOCIAL SECURITY:_____

I hereby authorize the release of any protected health information from my medical record which Texas Cardiac Arrhythmia deems necessary for my electrophysiology care. I understand the information disclosed may contain information on testing, diagnosis, and/or treatment for HIV, AIDS, sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that my receiving treatment with Texas Cardiac Arrhythmia will not be affected by my refusal to sign this form.

Information to be released /Información a divulgar:

_____History/Physical Consultation	_____Progress Notes	_____ Radiology
_____Electrophysiology Procedures	_____Operative Report	_____Holter/Event Monitor
_____Treadmill Tests	_____Nuclear Scans	_____Vascular Reports
_____Lab Reports	_____EKG/ECG	_____Polysomnograms
_____Echocardiogram	_____Discharge Summary	_____Chest X-rays
	_____Cardiac Cath. Report	

Other(Specify): _____

Specific Date of Service: _____

*Note: If no date of service is indicated, the request is for the most current information available.

This authorization does not expire. It may be revoked, but not retroactively on records already released in good faith.

_____ _____

Signature of patient Date

_____ _____

Parent/Legal Guardian/Legal Representative Witness Signature

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Section A: This section must be completed for all Authorizations			
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, eDelivery)** ☐ **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:**

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)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. 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.
4. 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.
5. 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.
6. 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:**