MEMORIAL CARDIOLOGY ASSOCIATES, P.A.

NEW PATIENT INFORMATION RECORD

(PLEASE PRINT)

PATIENT NAME: _____

LAST FIRST M

MAILING ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: _____ AGE: _____ DATE OF BIRTH: _____ MARRIED SINGLE DIVORCED WIDOWED

PATIENT SOCIAL SECURITY: _____ DRIVERS LICENSE#: _____

EMPLOYER: _____

PHONE NUMBERS:

HOME: _____ WORK: _____ CELL: _____

DAYTIME CONTACT NUMBER: _____

EMAIL: _____

INSURED'S NAME: _____ DOB: _____

EMPLOYER: _____ SOCIAL SECURITY: _____

IF PATIENT IS A MINOR (FILL OUT BELOW):

RESPONSIBLE PARTY: _____ PHONE: _____

ADDRESS: _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED:

NAME _____ PHONE: _____ RELATIONSHIP: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN (FAMILY PHYSICIAN): _____

PHONE NUMBER: _____

IF YOU NEED A REPORT TO BE SENT TO ANOTHER PHYSICIAN OTHER THAN YOUR PCP PLEASE PROVIDE

THE PHYSICIAN NAME: _____ PHONE NUMBER: _____

LIST MEDICATIONS YOU ARE ALLERGIC TO: _____

ASSIGNMENT AND RELEASE:

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MEMORIAL CARDIOLOGY ASSOCIATES. I ALSO AUTHORIZE MEMORIAL CARDIOLOGY TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY THAT THEY REQUEST SO THEY MAY PROCESS MY CLAIM.

DATE: _____ **SIGNATURE OF PATIENT/RESP. PARTY:** _____

PHILIP L. BERMAN, M.D., F.A.C.C. RANDALL E. MORRIS, M.D., F.A.C.C
STUART JACOBSON, M.D., F.A.C.C. MICHAEL M. MITSCHKE, M.D., F.A.C.C.

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 (NEW POLICIES EFFECTIVE 1-1-2013)

From MEMORIAL CARDIOLOGY, ASSOCIATES, P.A.

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 care operations).
   _____
   _____

2. Can confidential messages (i.e. appointment reminders and financial matters) be left on your telephone answering machine or voice mail.
   YES _____ NO _____

EMAIL:_____
For appointment reminders and possibly billing issues

BEST PHONE NUMBER TO CONTACT YOU BY: _____

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

_____ _____
SIGNATURE OF PATIENT DATE

_____
PRINT NAME OF PATIENT

_____ _____
SIGNATURE OF LEGAL REPRESENTATIVE OR GUARDIAN (if pt. is a minor) DATE

_____
WITNESS

MEMORIAL CARDIOLOGY ASSOCIATES, P.A
915 GESSNER, SUITE 900
HOUSTON, TX 77024

PHILIP L. BERMAN, M.D., F.A.C.C. RANDALL E. MORRIS, M.D., F.A.C.C
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OMAR G AWAR, M.D

1-1-15

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 physician payment. We are no longer able to extend credit indefinitely for services rendered nor are we able to shoulder the burden of billing and collections for small balances.

As a consequence, all patients of MCA/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 day grace period granted by the Affordable Care Act.

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

Thank You

Patients name:_____ **Date of birth** _____ **Acct#** _____

Email: _____

Credit card #_____ **exp:**_____

Three/four digit security code:_____ **Signature:**_____

Memorial Cardiology Associates

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FINANCIAL AND BILLING POLICY

EFFECTIVE JANUARY 1, 2015

PAYMENTS: We accept payment by CASH, CHECK, MONEY ORDER, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. We accept payments in the office and you can pay over the phone with a credit card. **Co-pays are collected at the time of the visit. This payment may cover the office visit only. Any additional procedures performed may fall under different benefits.** If you have any questions about your benefits, we will be happy to go over the insurance information we received from your insurance company prior to being seen. **Additionally, please be aware that this is your insurance policy and our verification is not a guarantee of payment.** We do accept payment plans.

REFERRALS: **Referrals must be obtained from your Primary Care Physician. It is the patient's responsibility to obtain the referrals.**

INSURANCES: If you have insurance we will file the claim on your behalf. It is the patient's responsibility to make sure we have the correct insurance information at the time of service. We use the most current insurance information when we send patients to an outside facility (hospital, lab companies, etc.). If we have the incorrect insurance information it is possible to send the patient to an out of network facility. The patient will be held financially responsible for these services. We are contracted with many insurance companies to make sure we are in network. If you have a secondary policy we will file it for the patient.

CASH PAY: If you do not have medical insurance coverage, we do accept payment plans. Please contact the business office for details. All patient's that do not have insurance (100% self-pay) will be offered a 30% prompt pay discount on any office visit & 50% on all other procedures excluding laboratory and medication charges.

Any further discounts will require financial hardship documentation.

MEDICARE: We are participating providers with Medicare and will file your claims. You will be financially responsible for your Medicare yearly deductible and/or the 20% of the Medicare approved amount. We will also file your secondary policy.

BILLING: We only send statements out to our patients when there is a balance owing by the patient or we need help with your insurance company. If you receive a statement and do not think that you owe the balance please contact the business office.
PLEASE DO NOT DISREGARD THE STATEMENTS.
We will send three statements without a statement fee. For every statement afterwards there will be a $5.00 statement fee each month. If the patient does not respond in any way, then by law, we must then start collection process. There will be a $100 collection agency fee. We do accept payment plans. We understand that medical expenses can be unexpected and expensive. We will work with the patient in resolving the balance. If you prefer, we do accept credit card authorizations over the phone.

RETURN CHECKS: There is a $25.00 charge for a return check and a $6.00 charge for the return receipt notification if the check has not been replaced in thirty days.

FORMS: There is a $75.00 charge to fill out FMLA papers and a $25.00 charge to fill out any other forms.

CANCELLATIONS: Please contact the office if you can't make the appointment. For continuous no shows there is a $25.00 charge.

We realize that financial matters are complicated, confusing and time consuming. If you have any questions or need additional information after today, you may contact the business office at (713) 464-0059, 9:00 AM to 4:30 PM.

Thank you,

Memorial Cardiology Associates.

Signature:_____ Date:_____

Name:_____ Age:_____ Date:_____

Why have you come to see the Cardiologist today?

_____

_____

Are you having any chest pain? YES NO

If yes, please describe below the duration, frequency, and location of the pain.

_____

_____

Do you get short of breath when the pain is occurring? YES NO

Does the pain cause nausea? YES NO

Does the pain make you sweat? YES NO

Can you feel your heartbeat or palpitations when pain is occurring? YES NO

Does the pain come with exertion or meals? YES NO

PAST MEDICAL HISTORY

Have you ever been diagnosed with high blood pressure? YES NO

If yes, how many years?

Have you ever been diagnosed with Diabetes Mellitus? YES NO

If yes, how many years?

Is your Diabetes insulin dependent? YES NO

Has your Diabetes caused kidney, eye, or nerve damage?

_____

Do you have high cholesterol or triglycerides? YES NO

If yes, are you taking cholesterol or triglyceride lowering medications? YES NO

Have you ever been diagnosed with Asthma, COPD, or Emphysema? YES NO

Do you suffer from Sleep Apnea? YES NO

Have you ever had a Stroke? YES NO

Have you ever had Rheumatic Fever? YES NO

Do you ever get stomach ulcers that bleed? YES NO

Name:_____ Date:_____

Have you ever had blood clots in your legs or in your lungs? YES NO

Have you ever been diagnosed with any type of heart disease? YES NO

If yes, have you ever had a heart attack, valve disease, or murmur?

Please list past surgical procedures and the dates of the procedures you have had.

_____

_____

_____

_____

_____

_____

Please list all medications, dosages, and strengths you are currently taking.

_____

_____

_____

_____

_____

_____

Are you allergic to any medications? YES NO

If yes, please list them._____

_____

Are you allergic to iodine? YES NO

Do you smoke? YES NO

If yes, how many packs per day and how long have you been smoking?

If you are a former smoker, please list how many packs per day for how many total years of smoking and how long ago did you quit?

Do you drink alcohol? YES NO

If yes, how much per week?

What is your current occupation?

If physical, please list the maximum weight lift required?

Name:_____ Date:_____

Family History

Has anyone in your family ever been diagnosed with heart disease? YES NO

If yes, please list all relatives and disease.

Has anyone in your family ever had a stroke? YES NO

If yes, please list all relatives that have had a stroke.

Has anyone in your family ever been diagnosed with high cholesterol? YES NO

If yes, please list all relatives with high cholesterol.

Has anyone in your family ever been diagnosed with cancer? YES NO

If yes, please list all relatives with cancer and the type cancer.

Has anyone in your family ever had blood clots in their legs or lungs? YES NO

If yes, please list all relatives and location of clots.

Has anyone in your family ever been diagnosed with Diabetes Mellitus? YES NO

If yes, please list all relatives with Diabetes Mellitus.