# Memorial Cardiology Associates

## NEW PATIENT INFORMATION RECORD

*(PLEASE PRINT)*

PATIENT NAME: _____ MRN:_____(office use only)
LAST FIRST MIDDLE

MAILING ADDRESS:_____

CITY: _____STATE: _____ZIP:_____

SEX:_____ AGE: _____ DATE OF BIRTH:_____

MARITAL STATUS:_____ EMAIL: _____

PATIENT SOCIAL SECURITY:_____DRIVER LICENSE NO._____

EMPLOYER:_____

HOME PHONE: _____ WORK PHONE:_____

CELL PHONE: _____ DAYTIME CONTACT NUMBER: _____

*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'S NAME: _____ PHONE NUMBER:_____

LIST MEDICATIONS YOU ARE ALLERGIC TO:_____

**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 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 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 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 to use and disclose my health information in accordance with this consent and the notice provided.

_____

PATIENT'S SIGNATURE/ RESPONSIBLE PARTY'S SIGNATURE DATE

# Memorial Cardiology Associates

## 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 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)**

# Memorial Cardiology Associates

## 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 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

_____ _____

Patient's Signature Date

# Memorial Cardiology Associates

## 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

**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 Memorial Cardiology Associates, PA HIPAA compliance literature.

_____ _____ _____

Patient's Name/ Responsible Party's Name Signature Date

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 Memorial Cardiology Associates, PA 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

# Memorial Cardiology Associates

**CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY**

I understand that as a part of my electronic health record, Memorial Cardiology Associates, PA will transmit my prescriptions electronically as permitted, to the pharmacy that I delegate as my primary pharmacy provider. Additionally, Memorial Cardiology Associates, PA will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record. E-Prescribing greatly reduces medication errors and enhances patient safety. Features of our ePrescribe program include:

- **Formulary and benefit transactions- Provides us with information about which drugs are covered by the drug benefit plan.**
- **Medication history transactions- Provides us with information about medications you are already taking.**
- **Fill status notification- Sends us an electronic notice that your prescription has been picked up.**

By signing this consent form you are agreeing that we can ePrescribe for you and request your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

____ I hereby provide informed consent to enroll me in the ePrescribe program.

____ I decline this option. I do not give permission for access to the above information.

Pharmacy Information:

Pharmacy Name:_____

Address: _____

Phone: _____Fax:_____

Patient's or Legal Representative's Signature:_____Date:_____

# Memorial Cardiology Associates

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 Rheumatice 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

## 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.