TEXAS CARDIOLOGY ASSOCIATES OF HOUSTON

DIAGNOSIS • INTERVENTION • VEIN CARE

Kingwood
2627 Chestnut Ridge Road , Suite 100
Kingwood, Texas 77339

Livingston
400 Bypass Lane, Suite 110
Livingston, Texas 77351

Liberty
720 Travis Street
Liberty, Texas 77351

Houston Northwest
800 Peakwood, Suite 6C
Houston, Texas 77090

Phone 281-358-1950 • **Fax** 281-358-1923 • **www.tcahouston.com**

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

Social Security #: _____ Date of Birth: _____ Sex: ____ M ____ F

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed ____ Separated Birth Place: _____

Race: ____ Declined ____ White ____ Black/African American ____ Native Hawaiian ____ Asian
____ American Indian/Alaska Native ____ Other Pacific Islander ____ More than 1 race

Ethnicity: ____ Hispanic/Latino
____ Not Hispanic/Latino
____ Decline

Preferred Language: ____ English ____ Spanish ____ Other: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Drivers License #: _____

Referring Doctor: _____ Primary Care Physician: _____

Home #: _____ Cell #: _____ Work #: _____

Employer Name: _____ Employer Phone #: _____

What is the best number to be reached at? ___ Home ___ Cell ___ Work

May we contact you by e-mail? ___ Yes ___ No ***May we contact you at work?*** ___ Yes ___ No

PRIMARY INSURANCE

Primary Insurance: _____ Insurance Phone #: _____

Insured Last Name: _____ Insured First Name: _____ M.I.: _____

Insured Social Security #: _____ Insured Date of Birth: _____ Sex: ____ M ____ F

Policy #: _____ Group #: _____

Relationship to Patient: _____ Insured Employer: _____ Employer Phone #: _____

****Please initial here if you do not have secondary insurance _____ ****

SECONDARY INSURANCE

Secondary Insurance: _____ Insurance Phone #: _____

Insured Last Name: _____ Insured First Name: _____ M.I.: _____

Insured Social Security #: _____ Insured Date of Birth: _____ Sex: ____ M ____ F

Policy #: _____ Group #: _____

Relationship to Patient: _____ Insured Employer: _____ Employer Phone #: _____

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Patient Name: _____

PHARMACY & EMERGENCY CONTACT INFORMATION

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

Emergency Contact Name: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

Name of family member not living with you: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

FINANCIAL POLICY

****** It is our office policy to inform you of our policies. Please review and initial both sections below******

Patients with Insurance: You are responsible for deductibles, copays, coinsurance, non-covered services and any services deemed "not medically necessary" by your insurance company. Please pay copay and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. Unpaid balances are subject to debt collection through an outside collection agency.

Workers Compensation Patients: We do not accept workers compensation

Self Pay Patients: Payment is due at time of service

Medicare Patients: Our office will submit your charges to Medicare and your secondary insurance. You are responsible for any deductibles, copays, coinsurance and non-covered services at time of service.

Referrals: If your insurance carrier requires a referral from your primary care/POS (point of service) physician for treatment by a specialist, it is your responsibility to obtain the referral. Failure to obtain a referral will result in rescheduling of your appointment until such time as a referral is received. If you wish to obtain services without a referral, you will be required to sign a waiver, which outlines your financial responsibility.

We accept cash, checks, Visa, Discover and MasterCard. If you are unable to make payments at each visit, please notify the front desk staff to make other arrangements.

☐ **Initial Here**

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payments directly to Texas Cardiology Associates of Houston and/or its physicians. I understand that I am responsible for any amount not covered by my insurance.

I hereby authorize Texas Cardiology Associates of Houston and/or its physicians to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims; (4) view health plan details and to appeal claims on the patients behalf; and (5) bill and receive payments directly from the insurance carrier. This order will remain in effect until revoked by me in writing.

I have requested medical services from Texas Cardiology Associates of Houston and/or its physicians on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

☐ **Initial Here**

I have read and agree to the Financial Policy and Assignment of Benefits/Release of Information paragraphs stated above that apply to me.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Print Name if Signing on Behalf of Patient Reason Patient Can't Sign

_____ _____ _____
Relationship to Patient Address Phone #

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PATIENT QUESTIONNAIRE

Name: _____ Date: _____

How did you hear about our office? _____

What other doctors do you see? _____

Reason for your visit today? _____

Have you had an EKG? _____ Y _____ N. If yes, where and how long ago? _____

Please list all medications, including	dosage &	frequency:		dosage	frequency
1. _____			5. _____		
2. _____			6. _____		
3. _____			7. _____		
4. _____			8. _____		

Do you have any allergies to latex, adhesives, or medications? _____ Y _____N. If yes, please list allergies: _____

_____

Have you been diagnosed with any medical conditions? _____

Is your father living? _____ Y _____ N. If yes, what is his state of Health? _____
If no, age of death _____ and cause of death _____
Is your mother living? _____ Y _____ N. If yes, what is her state of health? _____
If no, age of death _____ and cause of death _____
Do you have any brothers? _____ Y _____ N. If yes, how many _____ and what is his state of health? _____
Do you have any sisters? _____ Y _____ N. If yes, how many _____ and what is her state of health? _____
Do you have any children? _____ Y _____ N. If yes, how many _____ and what is his/her state of health? _____
Do you ever drink alcohol? _____ Y _____ N. _____ quit. If yes, is it occasional _____ moderate _____ heavy _____
Do you drink caffeine? _____ Y _____ N. If yes, is it coffee ___ tea ___ soda ___ . Servings per day? _____
Do you ever use tobacco? _____ Y _____ N. _____ quit. If yes, how often _____ , how long _____ and what type _____. If you quit, what was your age _____ and what year _____ did you quit.
What are your exercise habits? inactive _____ light _____ moderate _____ heavy _____
Frequency & duration of exercise _____
What are your nutrition habits? well balanced diet _____ special diet _____ poor balanced diet _____ vegetarian _____.
Do you take any dietary supplements or multivitamins? _____ Y _____ N.
What is your primary occupation? _____
List any major surgical procedures: _____

_____

List any other past medical history not listed above: _____

_____

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PATIENT NAME _____ **DOB** _____

Family History

Does your Father have history of: ◯ High Blood Pressure ◯ Diabetes ◯ CAD ◯ High Cholesterol
◯ Heart Problems ◯ Past Heart Attack ◯ Arrhythmias ◯ Lung Problems ◯ Cancer

Does your Mother have history of: ◯ High Blood Pressure ◯ Diabetes ◯ CAD ◯ High Cholesterol
◯ Heart Problems ◯ Past Heart Attack ◯ Arrhythmias ◯ Lung Problems ◯ Cancer

Do your Siblings have history of: ◯ High Blood Pressure ◯ Diabetes ◯ CAD ◯ High Cholesterol
◯ Heart Problems ◯ Past Heart Attack ◯ Arrhythmias ◯ Lung Problems ◯ Cancer

Do your Father's Parents have history of: ◯ High Blood Pressure ◯ Diabetes ◯ CAD ◯ High Cholesterol
◯ Heart Problems ◯ Past Heart Attack ◯ Arrhythmias ◯ Lung Problems ◯ Cancer

Do your Mother's Parents have history of: ◯ High Blood Pressure ◯ Diabetes ◯ CAD ◯ High Cholesterol
◯ Heart Problems ◯ Past Heart Attack ◯ Arrhythmias ◯ Lung Problems ◯ Cancer

Do your Uncles have history of: ◯ High Blood Pressure ◯ Diabetes ◯ CAD ◯ High Cholesterol
◯ Heart Problems ◯ Past Heart Attack ◯ Arrhythmias ◯ Lung Problems ◯ Cancer

Do your Aunts have history of: ◯ High Blood Pressure ◯ Diabetes ◯ CAD ◯ High Cholesterol
◯ Heart Problems ◯ Past Heart Attack ◯ Arrhythmias ◯ Lung Problems ◯ Cancer

Past Medical History

anemia	◯ Yes	aortic regurgitation	◯ Yes	aortic stenosis	◯ Yes
arthritis	◯ Yes	asthma	◯ Yes	CAD post stent	◯ Yes
Peripheral Vascular Dz	◯ Yes	atrial fibrillation	◯ Yes	atrial flutter	◯ Yes
bowel disorders	◯ Yes	bronchitis, chronic	◯ Yes	cardiac arrhythmia	◯ Yes
cardiac murmur	◯ Yes	cardiomyopathy	◯ Yes	carotid stenosis	◯ Yes
cataracts	◯ Yes	cirrhosis	◯ Yes	congestive heart failure	◯ Yes
coronary artery disease	◯ Yes	COPD	◯ Yes	deep vein thrombosis	◯ Yes
diabetes mellitus	◯ Yes	Diverticulitis	◯ Yes	emphysema	◯ Yes
end-stage renal disease	◯ Yes	Hypertension	◯ Yes	glaucoma	◯ Yes
gout	◯ Yes	heart murmur	◯ Yes	heartburn	◯ Yes
jaundice	◯ Yes	mitral valve regurgitation	◯ Yes	mitral valve stenosis	◯ Yes
renal failure	◯ Yes	sleep apnea	◯ Yes	stroke	◯ Yes

If you have history not listed above please write them here _____

Surgical History

Hernia repair	◯ Yes	vasectomy	◯ Yes	Gallbladder	◯ Yes
appendectomy	◯ Yes	tonsillectomy	◯ Yes	cesarean section	◯ Yes
pacemaker, cardiac	◯ Yes	CABG	◯ Yes	hysterectomy	◯ Yes
vascular bypass	◯ Yes	varicose vein stripping	◯ Yes	thyroidectomy	◯ Yes
cataract removal	◯ Yes				

If you have had a surgery not listed write it here _____

Hospitalization

Same as surgeries ◯ Yes

If you have been hospitalized for any other reason _____

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PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name (please print) _____ **Date of Birth** _____

I understand that my family members, friends, and co-workers may ask questions about my medical condition to include test results, appointments, and billing information over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my physician or physician's staff to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties listed below with whom I wish Texas Cardiology Associates of Houston to be able to discuss my medical condition to include test results, appointments, and billing information.

I hereby authorize Texas Cardiology Associates of Houston to discuss and release my medical information to the following individuals:

Name 1 _____ Relationship _____ Phone # _____

Name 2 _____ Relationship _____ Phone # _____

Is it ok to leave results on an answering machine? YES ☐ NO ☐

_____ **INITIAL HERE**

The below individuals are authorized to pick up any written prescriptions, medication samples or testing films on my behalf:

Name 1 _____ Relationship _____

Name 2 _____ Relationship _____

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded:

_____

Name of Patient (please print) _____ Date _____

Signature of patient or guardian _____ Relationship to patient _____

This authorization will be effective until revoked in writing by patient listed above.

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information **(PHI)** is going to be used by Texas Cardiology Associates of Houston and your rights concerning those records. Before we will begin any healthcare operations we must require you to read and sign this consent for stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Texas Cardiology Associates of Houston to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company or Companies provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions, but if it does, it is bound by the agreement.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke the consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke the consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the physician has the right to refuse to provide care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient (please print) _____ Date _____

Signature of Patient or Legal Guardian _____ Relationship to patient (self, parent, etc.) _____

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Ira II. Lieber. M.D., F.A.C.C.
Shakeel Uddin, M.D., F.A.C.C.
Syed A. Raza, M.D., F.A.C.C.
Xianfeng Wen, M.D., F.A.C.C.
Robert L. Salazar, M.D., F.A.C.C.
Mohamed F. Almahmoud, M.D., F.A.C.C.
Hassan Kamran. M.D.
Marloe Prince, M.D.
Elie Dib, M.D.

Medical Records Release Form

I understand Lieber & Moore Cardiology Associates dba Texas Cardiology Associates of Houston is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Texas Cardiology Associates of Houston or its designated employee(s) to disclose my Protected Health Information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

Please allow 7-14 days for copying. **There is a fee of $25.00 for the first 25 pages, $.50 cents per page after that and postage charges.** The medical records cannot be released until this form is completed and signed by the patient or legal guardian.

You must complete this form thoroughlv. Please print.

Patient Name:_____ Date of Birth:_____

Social Security #:_____

I hereby authorize Texas Cardiology Associates of Houston to ☐ **Release** and/or ☐**Obtain** my health information.

Name of Physician/Medical Facility:_____

Address:_____

Phone#:_____ Fax#: _____

1. **Description of the information to be used or disclosed (check as appropriate):**

☐ **a. My entire record:**

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical records including, but not limited to: demographic information, patient histories, medication lists, tests and diagnosis. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply):**

☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment
☐ Genetic Information (including, but not limited to, Genetic Test Results)

(NOTE: If you checked "my entire record", please skip to number 2. Otherwise, please continue with b and c below.)

☐ **b. My demographic information (check "All" or those that apply):**

☐ All ☐ Age ☐ Gender ☐ Race ☐ Other_____
☐ Name ☐ Address ☐ State/Zip Code Only ☐ Telephone

☐ **c. Medical Date/Information as related to (check all that apply):**

☐ Specific condition(s): _____
☐ Specific professional service(s): _____
☐ Specific medication(s): _____
☐ Alcohol and Drug Abuse Treatment:*
☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment: _____
☐ HIV/Acquired Immune Deficiency Syndrome (AIDS): _____
☐ Genetic Information including, but not limited to, Genetic Test Results: _____
☐ Other: _____

2. I ☐ do ☐ do not authorize this information to be disclosed electronically.

3. Purpose(s) for disclosure of the information:
Continuation of Medical Care

4. Right of Revocation: I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, Texas Cardiology Associates of Houston must receive the revocation in writing and the revocation must include:

a. My name and address
b. The effective date of this authorization and the recipients of the Protected Health Information according to this authorization
c. My desire to revoke this authorization, and
d. The date of the revocation and my signature

Texas Cardiology Associates of Houston will accept written revocation of this authorization via:
☒ Certified U.S. Mail
☐ Facsimile at this number: _____
All revocations must be sent to Custodian of Medical Records, and are not effective until received by him/her.

5. This authorization shall expire on N/A. After this date/event, Texas Cardiology Associates of Houston can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

6. I fully understand and accept the terms of this authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Name of Patient

_____ _____
Name of Representative (if applicable) Description of Representative's Authority to act for patient

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR OFFICE USE ONLY

☐ Authorization added to the patient's record on _____
☐ Authorization verified by _____
☐ Patient has been provided with a copy of the signed authorization

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Consent to Enroll in Patient Portal

Our Patient Portal offers access to:

- Send and receive messages with our clinical staff
- You can request medication refills
- View upcoming appointments

Once you have consented to activate your portal, you should receive your login credentials within 24 hours of activation to your email address on file.

Patient Name: _____

Patient DOB: _____

Patient Email: _____

Patient Signature: _____

Staff Initials: _____ **Date of Activation:** _____