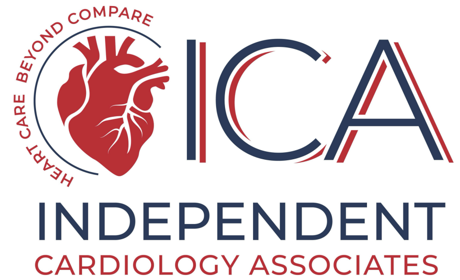

New Patient Form

Date:___________________________

Patient Information

Last Name: ____________________________ First Name: ____________________________ M.I:________

Social Security #:______________________ Date of Birth: ____________________ Gender: Male Female

Address:____________________________ Apt#________ City:________ State: ________________________

Zip Code: __________________________ Driver's License: State:________ Number:_________________________

Home Phone: (____)______________ Work Phone: (____)______________ Cell Phone:(____)______________

Email address:____

For the bolded questions below, please answer in the spaces provided or circle all answers that apply to you.

Race:

Asian Black/African American Native American White Other Unknown or not reported

Ethnicity:

Hispanic or Latino Not Hispanic or Latino Unknown or decline to report

Language:

English Spanish Russian Refused to Report Unreported Other

Other Physicians:

Primary Care Physician: __________________________________Phone Number: (____)_________________

Referring Physician:_______________________________________Phone Number: (____)_________________

Marital Status:

Married Single Divorced Widowed/Widower Life partner

Children:

Yes No Number of Sons:___________ Number of Daughters:___________

Employment Status:

Employed Retired Unemployed

Employer:____________________________________ Occupation: ___________________________

Address:_____________________________________ Phone number: (_____)_________________

Name:_________________________ DOB:________________

In the space below please describe your problem(s) that you are having now. Please include when the problem first presented, how severe your problem is and any contributing factors to your ailment.

____

____

____

____

Have you ever used tobacco?

No/ Never Yes, formerly Yes, currently

Tobacco Type: Cigarettes Chewing Tobacco Pipe Tobacco Snuff

Age Started:_______________ Age Stopped:________________

Quantity per Day:___________ Total years used:_____________

Diabetes: Have you ever been diagnosed with diabetes? Yes No Unknown

Type: 1 2 Year Diagnosed: ___________________

Dyslipidemia: Have you ever had abnormal Cholesterol? Yes No Unknown

Type:____________________ Year Diagnosed:_______________________

Family History Premature Coronary Artery Disease Has anyone in your family younger than the age of 60 had Coronary Artery Disease?

Yes No Unknown Adopted

Hypertension Have you ever been diagnosed with high blood pressure? Yes No Unknown

Year Diagnosed:_______________________

Peripheral Vascular Disease: Have you ever been diagnosed with PVD? Yes No Unknown

Year Diagnosed:_______________________

Alcohol consumption: Do you drink alcohol? Yes No

Frequency:________________ Amount:________________ Last Drink:__________________

Caffeine Consumption: Do you drink/ consume caffeine? Yes No

Type(s):_________________ Frequency:________________ Amount:___________________

Recreational Drug Use: Do you use any drugs recreationally, including marijuana? Yes No

Type(s):_________________ Frequency:________________ Amount:____________________

______ **Please initial here if you consent to having confidential information in Social History Document**

Name:________________________ DOB:________________

In the space below, please note your family members current health status to better allow us to treat you. Specifically, please note if your family members have a history of coronary artery disease, heart attacks, high blood pressure, high cholesterol, stroke, diabetes, sudden death, heart failure and / or cancer? (Please circle Alive and Well, Alive and diagnosed or Deceased; then note the cause of death or diagnosis if known and the age at which the disease was first diagnosed)

If you were adopted, please initial here_____________

Father:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset:____

Mother:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset:____

Brother:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset:____

Sister:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset:____

Daughter:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset:____

Son:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset:____

In the space below please include grandparents or other family members not listed above.

____

____

____

Past medical history (Circle all that apply)

Heart Disease
Heart Valve Problems
Blood clot in the Lungs
Heart Failure
Hereditary Heart Defect
Heart Murmur
Blood Clot in the Legs
Hepatitis (A, B, or C)
Lung problems
Kidney Disease
Thyroid disease
HIV disease/exposure
Diabetes
Stroke/TIA
Asthma
Cancer
Liver Disease
Bleeding
Pacemaker
Heart Block
Previous Heart Attack
High Blood Pressure
Emphysema

Comments:

____

Name:________________________ DOB:________________

Please provide information about previous SURGERIES (Include date or Year)

Coronary Bypass:____________________________ Date:____________________

Cardiac Cath/ Angiogram/ Stent:________________ Date:____________________

Pacemaker/ ICD:____________________________ Date:____________________

Please List any Medication Allergies and Drug Reaction:

Pharmacy Name and Phone number:____

Please use the space below, and present at the time of your appointment, a list of all of your current medications, vitamins, and supplements. This will help us better serve you. Thank you!

Please print clearly.

Name of Medication (s)	Dose (Mg/ mcg/ etc)	Amount Taken Daily (How many tablets, caps or injections per day)

Use the back of this page as needed

Name:_________________________ DOB:_________________

PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

I grant permission to Independent Cardiology Associates to disclose Health information in the following manner:

By my initials, I recognize that electronic mail is **Not** a secure form of communication.

Communicate information via electronic mail:___________________________________

Leave a message on my voicemail/answering machine at home:__________________ Phone #:________________

Leave a message on my voicemail/answering machine at work:___________________ Phone #:________________

Leave a message on my voicemail on my mobile phone:__________________________ Phone #:________________

EMERGENCY CONTACT AND PERMISSION TO COMMUNICATE

Please fill in the following questions and circle selected options that apply to you.

Name:________________________ Relationship:__________________________ Ph:_________________________

Leave Msg Ok to speak with No communication unless urgent

Name:________________________ Relationship:__________________________ Ph:_________________________

Leave Msg Ok to speak with No communication unless urgent

Name:________________________ Relationship:__________________________ Ph:_________________________

Leave Msg Ok to speak with No communication unless urgent

The type and amount of information that I authorize to be disclosed is as follows (please circle all answers):

Laboratory Results Radiology Results (X-rays, ultrasounds, etc.) Billing information

Prescription drug information Medical instructions or advice Insurance information

Appointment information, including confirmation/cancellation of appointment and type of appointment.

By signing this form, I understand that protected health information may be left on an answering machine as I have indicated above.

____ __________________________________

Signature of Patient or Authorized Representative Date

Name:________________________ DOB:________________

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you may have access to this information. Please review carefully!

Independent Cardiology Associates is permitted by Federal Privacy laws to make uses and disclosures for your health information for purposes of treatment, payment and health care operations.

We use health information about you, for your treatment, to be paid for your treatment, for continuity of care by sharing your information with other physicians involved in your total care and for various quality of care evaluations and outcome evaluations.

Our practice may contact patients to provide appointment reminders or information reminders of information about treatment alternatives or other health related benefits and service that may be of interest to you. This information may be shared by land mail, e-mail, fax, telephone, or other methods. Independent Cardiology Associates will attempt to accommodate reasonable requests, made in writing, to communicate by alternative means or at alternative locations.

We may have to disclose personal health information about you without your authorization for public health activities; to your family if you are seriously ill and unable to communicate; for reporting abuse, neglect or domestic violence; for health oversight activities; for judicial and administrative proceeding; for law enforcement purpose; for organ donations; for coroners, medical examiners and funeral directors; for specialized government functions and to avert serious threat to health and safety.

Our practice may disclose information to research when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Other uses and disclosures will be made only as otherwise required by law or with your written authorization. Such authorization may be revoked later, stop future uses or disclosures.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are physical property of Independent Cardiology Associates. The information in the records, however, belongs to you. **You have the right to:**

- Request a restriction on the use and disclosure of certain health information - **we are not required to grant the request**; unless the individual pays for the health care item or service in full on an out-of-pocket basis;
- Receive confidential information by alternative means or at alternative locations - we will attempt to accommodate reasonable requests presented to Independent Cardiology Associates in writing;
- To inspect and obtain a copy, at normal photocopy costs, of your confidential information - if Independent Cardiology Associates maintains the individual's PHI as an electronic health record, the individual also has the right to request and receive the PHI in electronic form - requests should be presented in writing - there may be legal exceptions to this right - you may contest the denial of access to your information by writing to Independent Cardiology Associates's HIPAA Compliance Officer;
- To request in writing that we amend your confidential information or change your demographic information. You must provide the reason for the request. We may deny your request for amendment if we determine that: we did not create the information; the law does not allow you to amend the information; your request to amend is denied, you will be told the reason and you may submit a statement showing why you disagree with the decision and this statement will be kept with your records;
- To receive an accounting of disclosures of your confidential information for uses other than disclosures of intimation for treatment, payment or healthcare operations during the prior three years.
- To receive a paper copy of the notice

Name:___________________________ DOB:__________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of Independent Cardiology Associates' Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Independent Cardiology Associates' privacy practices or my rights regarding my personal health information, I may contact your Compliance Officer at: 1001 12th Ave, Suite 156, Fort Worth, Texas-76104. 817-595-0050 for further information as set forth in the notice.

______________________________________ ______________________

Printed Name of Patient or Patient Representative Patient's Date of Birth

______________________________________ ______________________

Signature of Patient or Patient Representative Date

If signed by Patient's personal representative, State Representative's authority to act on behalf of the patient.

*****STAFF USE ONLY*****

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________ Patient's Date of Birth: ________________________

I hereby certify on _____/_____/_____(MM/DD/YR), I made a good faith effort to obtain the above patient's written acknowledgment of receipt of Independent Cardiology Associates' Notice of Privacy Practices, but I was unable to do so for the following reason(s).

____

____

____

Name of Staff Person

______________________________________ ______________________________

Signature of Staff Person Date

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.

Texas Regional Health Information Organization

Independent Cardiology Associates endorses, supports, and participates in electronic Health Information Exchange (HIE) to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the PULSE HIETexas, or cancel an opt-out choice, at any time.

Name:________________________ DOB:________________

Primary Insurance Information

Insurance Name:____Phone: ______________________

Address: ____City: ______________________State: ________Zip: ___________

Member ID/Policy #: __________________________________Group #: ______________________Copay: ___________________

Primary Policy Holder Name: Last: _________________________________ First:____________________________________

Date of Birth: ___________/___________/ _____________ Social Security#: __________________________ Sex: M F

Relationship to Patient: _______________________________

Secondary Insurance Information

Insurance Name:____Phone: ______________________

Address: ____City: ______________________State: ________Zip: ___________

Member ID/Policy #: __________________________________Group #: ______________________Copay: ___________________

Primary Policy Holder Name: Last: _________________________________ First: ___________________________________

Date of Birth: ___________/___________/ _____________ Social Security#: __________________________ Sex: M F

Relationship to Patient: _______________________________

Emergency Contact (not at same address): _________________________________Relationship:_____________________________

Home Phone: (______)________________Work: (______)_______________Cell: (______)________________

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/ or surgical benefit for services rendered by Independent Cardiology Associates to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Independent Cardiology Associates.

I understand that I am financially responsible for the amount not covered by insurance including, co-payments, co-insurance, and deductibles. I also agree that it is my responsibility to understand my insurance coverage and to verify that appropriate referrals, or pre-authorizations required by my insurance coverage are in place before the service is rendered. A photocopy of this assignment is to be considered valid as an original.

I hereby authorize said assignee to release information necessary to secure payment. The assignment will remain in effect until revoked by me in writing.

Signature of Patient or Authorized Representative

Date

GENERAL POLICIES

Thank you for choosing Independent Cardiology Associates (ICA) as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your understanding of our policies is important to our professional relationship.

1. I understand that medications are unable to be refilled if I have not followed up within the requested interval.

2. I understand that I may be charged for telephone visits with the provider.

3. I may be asked to reschedule if I am more than 15 minutes late for my appointment.

4. I understand I will be charged fees in accordance with Texas law for copies of my medical records.

5. I understand I may be charged a fee of $25 for each letter, FMLA, or disability form prepared by ICA.

6. I understand I will be charged a **$50 fee for no shows or cancellations within 24 hours** of the scheduled appointment. This will be billed directly to you or charged to a card on file. (Unless exempt per insurance requirements)

7. I understand that there will be a 2.99% surcharge on all credit card transactions (debit cards, HSA and active military are exempt from this charge).

____ ____________________
Signature of Patient Date

____
Printed Name of Patient

FINANCIAL POLICIES

Please understand that Independent Cardiology Associates financial policies are established to ensure the financial resources needed to maintain this medical office for all our patients. We must emphasize that as a health care provider our relationship is with you and not your insurance company.

It is your responsibility to inform our office of any patient information changes including name, address, and insurance information.

Please read and sign the following financial policies indicating your understanding of these policies and accepting financial responsibility for all services provided. Please ask us if you have any questions about our fees, policies, or your responsibilities.

Insurance

- The patient is required to present an insurance card at each visit. It is the patient's responsibility to make sure that all insurance information given to our office is correct and current, including both primary and secondary insurance. Failure to provide us with correct insurance information could result in your insurance company rejecting your claims for failure to obtain authorization, timely filing or other reasons and may result in your responsibility for the entire bill.

- ICA will bill your insurance company. It is your responsibility to verify your coverage and adhere to the restrictions of your plan. Your insurance is a contract between you, your employer if applicable, and your insurance company. Please contact your insurance company and/or your employer's human resource department with regards to your benefit questions. Although we may estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility and benefits.

- You may be responsible for charges incurred in this office that are not paid by your insurance company, including those applied to your deductible or coinsurance, in accordance with ICA's fee schedule and terms, regardless of insurance coverage. We don't always know if you have a deductible, if your deductible has been met, or if you have coinsurance.

- We expect payment in full of deductible and coinsurance balances within 30 days of statement receipt unless prior payment arrangements have been made. If services are performed or appointments made that are not covered by your insurance plan, you may be responsible for payment. We may ask that non-emergency appointments be rescheduled if copayment is not paid.

- I authorize my insurance company to make payments directly to ICA. I authorize the release of any medical information necessary to process claims and/or pursue payments of this account.

Self-Pay or Insurance ICA does not participate with

- You will need to sign a self-pay waiver if you have no insurance. This waiver clarifies your financial responsibly and helps prevent misunderstandings.

Referrals

- It is your responsibility to list a physician if your insurance company requires a PCP and call for a referral if one is required. Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist.

- Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance may be your responsibility.

Imaging, Monitor, Device, and Laboratory Fees

- Imaging, Monitor, Device and Laboratory services are performed and billed by an outside provider. You will be billed from their facility and all payments, questions or other concerns should be directed to their billing office. Independent Cardiology Associates cannot accept payments or adjust these outside provider charges.

Returned Checks

- There may be a $50.00 charge in addition to any charged bank fees for returned checks. This fee will be applied to my debit/credit card on file or billed directly to you. All future payments must be paid with a debit/credit card or cash.

Payment

- I understand that ICA recommends that a credit card (we accept Visa, Mastercard, and Discover), debit card (ACH), or health savings account card be kept on file and will be billed for any balance owed by the patient.

- If the credit card or health savings account card I provide on file is declined, I understand that I may be charged an extra $50 re-processing fee.

- Accounts past due are subject to collection proceedings and ultimately dismissal for full collection accounts.

- I agree that if my account becomes delinquent, I will be responsible for Attorney Fees, Legal Costs or any other costs of collection that may be incurred in order for ICA to obtain payment.

- Payments can be made in office, by phone at (817) 595-0050, online at icanorthtexas.com, or by mail.

I take responsibility for researching the costs of my visit and any procedures related to the visit with my insurance company and understand that costs not covered by certain insurance will be charged to me. I understand that I can discuss any visit related charges ahead of the visit with Independent Cardiology Associates' billing department at 1.800.288.3351.

I have read and accept the terms of this financial policy.

____

Printed Name of Financial Responsible Party

____ ____________

Signature of Financially Responsible Party Date

TELEMEDICINE CONSENT

Name: ______________________ Date of Birth ____________ Today's Date/Time_____________

Introduction:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to communicate with patients for the purpose of improving patient care. Providers may include primary care practitioners and specialists.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling patients to remotely contact their medical provider.
- More efficient medical evaluation and management

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images, lack of in person physical exam and other procedures such as spirometry) to allow for appropriate medical decision making by the physician and consultant(s)
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors

Initial: ______

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me such as in person patient visits, and that I may choose one or more of these at any time.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
6. I agree that the use of telemedicine is at the discretion of my provider and if deemed inappropriate for my condition, it will not be used as an appropriate visit type.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

______________________________ ____________
Patient Signature Date