HUMBLE CARDIOLOGOY ASSOCIATES

DR. MADAIAH REVANA, M.D., F.A.C.C.
9950 Memorial BLVD Suite 201
Humble, Texas 77338
PH: 281-446-4638/ FAX: 832-412-7917

NEW PATIENT INFORMATION:

Name: (First) _____ (Middle) _____ (Last) _____

Date of Birth: _____ Age: _____ Sex: (Male) ___ or (Female) ___

Race/Ethnicity: _____ Social Security Number: _____

Home Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Check appropriate box: Minor ____ Single ____ Married ____ Divorced ____ Widow ____ Separated ___

Employer: (Company Name) _____ Occupation: _____

Supervisor Name: _____ Phone Number: _____

How would you prefer to be reminded of upcoming appointments: Please check preferable box or boxes

Text Msg: _____ Email: _____ Automated phone reminders: _____

Whom may we thank for referring you? _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

RESPONSIBLE PARTY:

Name: _____ Relationship: _____

Date of Birth: _____ Phone: _____

EMERGENCY CONTACT: (Person to contact in case of any emergency)

Name: _____ Relationship: _____

Phone:_____ Alternate Phone: _____

I herby consent that this information is accurate and true to my acknowledgement

Signature: _____ Date: _____

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FINANCIAL POLICY:

Thank you for choosing HUMBLE CARDIOLOGY ASSOCIATES/NORTHEAST HOUSTON VEIN CENTER. We are committed to your satisfaction. Please assist us in meeting your expectations by reviewing the Financial Policy below.

FORMS:

You will be asked to complete a registration form which will include your home address, telephone number, social security number, as well as the address and telephone number of your insurance company if applicable. Insurance company information can generally be obtained from a card provided to the member and we prefer to make a copy of the card for our records. We also request a copy of your Driver's License or other picture Identification to include in your records.

FORMS OF PAYMENT:

For your convenience, we accept Cash, Checks, Debit and Credit Cards. We must have a copy of your Drivers Licenses or ID to accept checks.

OFFICE VISITS:

All office charges are payable at the time the services are rendered, provided we are not filling with your insurance carrier. For your convenience, we will provide you with a copy of the superbill documenting the charges and receipts for your visits (at your request).

CLAIM FILING:

Humble Cardiology Associates and Northeast Houston Vein Center is contracted with many managed plans. We will file your insurance in accordance with our agreement with the plan. Any co-payment for which you are responsible must be paid at the time of service, **NO EXCEPTIONS**. Although we can assist you in many ways, it is your responsibility to be familiar with the coverage provided by your insurance plan, particularly with respect and preventative care, Immunizations, the authorization of any procedures and your primary care physician. Should your insurance plan require a referral, it will be your responsibility to obtain and furnish us with the referral at the time of service. If a required referral is **NOT** provided, **NO SERVICES WILL BE RENDERED**. Please let us know of any changes to your insurance plans or personal contact information when you call to make an appointment. It will be your responsibility to pay for any services NOT covered or paid by your insurance carrier. If benefits and eligibility cannot be verified prior to service, you may be required to pay for services in full. Any charges DENIED by your insurance will be your responsibility.

FINANCIAL RESPONSIBILITY FOR MINORS:

Unless prior arrangements have been made, charges for a minor child seen in the office will be the responsibility of the Parent or Guardian of the minor.

HOSPITAL FEES:

You are responsible for your hospital fees; payment arrangements can be made with our business office. In the event you have insurance for hospitalization, all fess for hospital services will be filed with your insurance company upon discharge from the hospital. Any deductible or co-payment will be due when invoiced by HUMBLE CARDIOLOGY ASSOCIATES.

QUESTIONS: If you have any questions concerning charges, filling insurance plans or billing, please contact our business office at 281-446-4638.

I guarantor, have read and agree to the terms regarding payment and payment responsibility.

PRINT NAME: _____ **DATE**: _____

SIGNATURE: _____ **DATE**: _____

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CONSENT FORM:

CONSENT TO THE USE AND DISCLOSURE OF THE HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my medical history, symptoms, examination and testing results, diagnosis, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and evaluation to my bill
- A means by which a third-party can verify that services billed were actually completed by a healthcare professional.

I understand and have the opportunity to review the **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent form. I understand that the organization reserves the right to change their notice and practices prior to implementation will mail copy of any revised notice to the address that I have the right to request restrictions as to how my health information may be disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken actions in reliance thereon.

- RESTRICTIONS: _____
- I have requested the following people the use or disclosure of my health information (please list names and relationship to patient that medical information may be released to):

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

Print Name: _____ Signature: _____

Witness: _____ Date: _____

Your name and signature indicate that you have had the opportunity or have received a requested copy of HUMBLE CARDIOLOGY ASSOCIATES/NORTHEAST HOUSTON VEIN CENTER Notice of Privacy Practices on the date indicated. If you have any questions regarding the information set forth in HUMBLE CARDIOLOGY ASSOCIATES/ NORTHEAST HOUSTON VEIN CENTER Notice of Privacy Practices, please feel free to contact our Medial Records Department at 281-446-4638.

Signature: _____ Date: _____

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ASSIGNMENT OF BENEFITS:

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

I hereby assign convey directly the above-named healthcare provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named healthcare provider, regardless of its managed care network participations status. I understand that I an financially responsible for ALL charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named healthcare provider to release all medial information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer and/or attorney to release to the above-named healthcare provider all documents, summary of benefit description, insurance policy and/or settlement information upon request from the above-named healthcare provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or covey to the above-named healthcare provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies and/or medications I receive for the above-named healthcare provider (including any right to purpose those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named healthcare provider all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies and/or medications provided by the above-named healthcare provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me, (2) submit evidence, (3) make statements about facts or laws, (4) make any request including providing or receiving notice of appeal proceedings, (5) participating in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, healthcare benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such healthcare benefit plan, employee plan, plan administrator or insurance company in my name with derivative standing at providers expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of the assignment is to be considered valid, the same as if it was original.

I have read and fully understand this agreement: Sign: _____ Date: _____