Heart and Vascular Care

Bhupinder Singh MD, PA
1600 Coit Road
Suite 207
Plano, TX 75075

Patient Information

Name: ____
(Last) (First) (MI)

DOB____________ SS#________________ Address:______________________________

____

Home #:__________________ Cell#:__________________ Work#:__________________

Marital Status: S M D W ; Ethnicity: White African American Asian Latino Race:______________

Language:________________________ Email:______________________________

Primary Care Physician: ______________________________ Phone: ______________

Emergency Contact:

Name: ____________________________________ Phone#:__________________
Name:____________________________________ Phone #:__________________

Insurance Information:

	Insurance Name	Members ID	Group #:
Primary:	____________________	____________________	________________
Secondary:	____________________	____________________	________________
Third:	____________________	____________________	________________

PLEASE GIVE INSURANCE CARD(S) AND PHOTO ID TO FRONT DESK

I hereby assign my insurance benefits be paid directly to my physician. I agree to be financially responsible for all rendered services on my behalf or on behalf of my dependents. I also authorize the physicians to release any information acquired in my examination on my dependents to third party payers or other health practitioners involved in my care.

*I also understand that payments are expected at the time of visit unless otherwise arranged.

Signature: ______________________________ Date: ____________________

Heart and Vascular Care
Bhupinder Singh MD PA
1600 Colt Road
Suite 207
Plano, TX 75075
Phone: 972-612-0388/Fax: 972-612-0389

Financial Policy and Patient Responsibility

- Health Insurance is a contract between the patient and their Health Insurance Company or employer. Patients are ultimately responsible for understanding the details of their medical insurance coverage including but not limited to:
  - **Knowing if we are In-Network with your insurance carrier and your particular plan.** *If we are Out-of Network with your plan, you will be responsible for any uncovered expenses.*
  - **Pre-Authorization and Pre-Certification requirements for testing.** As a courtesy to our patients, we try to obtain pre-authorization and pre-certification. However, it is ultimately the patient's responsibility to know their authorization requirements.
  - **Knowing if a referral is needed by your Primary Care Physician (PCP).** Most HMO plans require a referral letter from the member's PCP to a specialist before the specialist services are covered.
- To know and understand the following patient financial responsibilities for their plan:
  - **Deductible** – the amount for which a patient is obligated to pay *out of pocket before* certain services are paid by their plan. Many plans will not pay for testing until after the deductible is met. This means the patient may have 100% financial responsibility for testing until after the deductible is met. Many plans have an individual and a family deductible.
  - Co-Pay – the out of pocket patient responsibility of a patient for an office visit.
  - **Co-Insurance** – a percentage or dollar amount for which a patient is responsible.
  - **Premium** – a monthly, quarterly or annually payment made to your insurance carrier to maintain active coverage status. Premiums are in addition to deductibles, co-pays and co-insurance.
  - **Maximum Out of Pocket** - The maximum financial responsibility of the patient for the plan year. Deductibles, Co-Insurance and Co-Pays are all applied to the out-of-pocket maximum. Once the out-of-pocket maximum is met for the plan year, the insurance carrier is responsible for 100% of the remaining medical expenses as long as they are provided by in-network providers.
- **To be aware of your Explanation of Benefits (EOB's)** and to facilitate in claims payments when their insurance carrier *denies all or part of a claim.*
- **To inform our office immediately of any insurance coverage changes.** Failure to do this may result in not being able to see patients at their scheduled time.

Please contact your insurance carrier if you have any questions about your coverage and your financial obligations based on your plan. The number for member services is usually on your insurance identification card.

Financial Policy Acknowledgement: I have read and understood the above financial policy; I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

Patient Name (please print) ____________ Signature ____________ Date ____________

Heart and Vascular Care

Bhupinder Singh, MD

Authorization for Disclosure of Health Information:

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Patient Name:________________________________ Date of Birth:_____/_____/_____

Address:____

City:______________________________State: __________Zip:___________

E-mail Address:______________________________Phone:_______________

I request that my protected health information (PHI) from {healthcare facility name} be disclosed to:

Recipient Name: Dr.Bhupinder Singh,MD

Address: 1600 Colt Road, Suite 207 __________ City: Plano _____State: Texas ___Zip:75075 _____

Phone: (972)612-0388 ________Fax: (972)-612-0389 ____________

REASON FOR DISCLOSURE (Choose only one option below)

☐ Treatment/Continuing Medical Care

☐ Personal Use ☐ Billing or Claims

☐ Insurance Legal Purposes ☐ Disability Determination ☐ School

☐ Employment ☐ Other ____________________

INFORMATION THAT CAN BE DISCLOSED:

Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ All health information ☐ *History/Physical Exam* ☐ *Past/Present Medications* ☐ Lab Results

☐ Physician's Orders ☐ Patient Allergies ☐ Operation Reports ☐ Consultation Reports

☐ Progress Notes ☐ Discharge Summary ☐ Diagnostic Test Reports ☐ EKG/Cardiology Reports

☐ Pathology Reports ☐ Billing Information ☐ Radiology Reports & Images ☐ Other____________

Signature______________________________________ Date:____________________

CANCELLATION AND NO SHOW POLICY

Office appointments which are cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee. Procedure cancellations require 5-7 business day advance notice, without notification they may be subject to a $50 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a $25.00 fee for office appointment No Show and *$50 procedure No Show fee.*

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (972-612-0388).

Please sign that you have read, understand and agree to this cancellation and no show policy.

______________________________ Date of birth __________

Patient Name (Please Print)

______________________________ __________________

Signature of Patient or Patient Representative Date

By signing this authorization form, I understand that:

I understand that this health information may include sensitive information. By signing this form I am specifically authorize the release of information relating to:

- ☐ Substance Abuse Treatment information
- ☐ HIV related information, including AIDS related testing
- ☐ Mental Health Information

Signature____

Date:____________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS. 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 whom it pertains or as otherwise permitted by 42 C.F.R.

• Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: (ADDRESS). Revocation will not apply to information that has already been disclosed in response to this authorization. • Unless otherwise revoked, this authorization will expire on the following date/event/condition: ______________________________.

If I fail to specify an expiration date/event/condition, this authorization will expire (insert time frame) from the date signed.

• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization

____________________________________ Patient or Authorized Representative

Signature Date ________________________

____

Print Name /Relationship to Patient (if applicable)

New Patient Health Questionnaire

Date:___/____/________

Patient: ______________________________

Gender: ☐M ☐F

Date of birth:_____/_____/_________; Age:_________;

Referring Doctor:______________________________

Please INDICATE all the reasons for your visit.

1. ☐Chest pain ☐at rest ☐with exertion
2. ☐Shortness of Breath ☐at rest ☐with exertion
3. ☐Palpitations / irregular heart rate
4. ☐Racing heart
5. ☐Swelling legs
6. ☐Dizziness / Fainting
7. ☐Hypertension
8. ☐Heart failure
9. ☐Pre surgical evaluation
10. ☐Establish new cardiologist

H1. PRIOR HEART DISEASE AND TESTING? ☐YES: ☐NO (Next Section)

Heart murmur / valve prolapse.......... ☐NO ☐YES: YEAR; ________
Rheumatic / Scarlet fever.......... ☐NO ☐YES: YEAR; ________
Angina / Chest pain.......... ☐NO ☐YES: YEAR; ________
Heart attack.......... ☐NO ☐YES: YEAR; ________ Location: __________
Heart Cath / Angioplasty / Stent.......... ☐NO ☐YES: YEAR; ________ Location: __________
Bypass surgery.......... ☐NO ☐YES: YEAR; ________ Location: __________
Pacemaker.......... ☐NO ☐YES: YEAR; ________ Location: __________
Defibrillator.......... ☐NO ☐YES: YEAR; ________ Location: __________
Heart failure.......... ☐NO ☐YES: YEAR; ________
Stress test (treadmill).......... ☐NO ☐YES: YEAR; ________ Location: __________
Echo / Ultrasound.......... ☐NO ☐YES: YEAR; ________ Location: __________
Calcium Scoring.......... ☐NO ☐YES: YEAR; ________ Location: __________
Nuclear Thallium PET Scan.......... ☐NO ☐YES: YEAR; ________ Location: __________
Carotid ultrasound.......... ☐NO ☐YES: YEAR; ________ Location: __________
CT Angiogram.......... ☐NO ☐YES: YEAR; ________ Location: __________
Holter (24 hr monitor).......... ☐NO ☐YES: YEAR; ________ Location: __________

H2. RISK FACTORS FOR HEART DISEASE:

High cholesterol.......... ☐NO ☐YES: YEAR; ________ TC___LDL___HDL___TG____
High blood pressure.......... ☐NO ☐YES: YEAR; ________
Diabetes.......... ☐NO ☐YES: YEAR; ________ Hormones ☐Y / ☐N
Current Smoker.......... ☐NO ☐YES
Previous Smoker.......... ☐NO ☐YES QUIT YEAR; _________
Phen / Fen weight loss medicine.......... ☐NO ☐YES: YEAR; ________

H3. BLOOD VESSEL DISEASES

Carotid disease or endarterectomy.......... ☐NO ☐YES: YEAR; ________
Stroke or TIA (ministroke).......... ☐NO ☐YES: YEAR; ________
Aortic aneurysm.......... ☐NO ☐YES: YEAR; ________ Surgical Repair YEAR; ________
Numbness or tingling of legs.......... ☐NO ☐YES: YEAR; ________
Leg cramps while walking.......... ☐NO ☐YES: YEAR; ________
Venous thrombosis (leg clots).......... ☐NO ☐YES: YEAR; ________
Pulmonary embolism (lung clots).......... ☐NO ☐YES: YEAR; ________

MEDICATIONS:

Please list all prescription and non-prescription medicines including vitamins and aspirin.

	NAME	DOSE/STRENGTH	FREQUENCY
Example	Lasix	40 mg.	2 in am / 1 in pm
1.	________	________	________/________
2.	________	________	________/________
3.	________	________	________/________
4.	________	________	________/________
5.	________	________	________/________
6.	________	________	________/________
7.	________	________	________/________
8.	________	________	________/________
9.	________	________	________/________
10.	________	________	________/________
11.	________	________	________/________
12.	________	________	________/________

H4. DO YOU HAVE ANY ALLERGIES TO MEDICINES? ☐NO (next section) ☐YES

Please list all medications to which you have an allergy or adverse response and list the reaction (e.g. penicillin-arm rash)

	Medication	Reaction
1.	________	________
2.	________	________
3.	________	________
4.	________	________

Are you allergic to iodine, shrimp or shellfish? ☐NO ☐YES

Have you received X-ray contrast (myleogram, IVP, CT Scan)? ☐NO ☐YES

If Yes, did you have any reaction to the contrast? ☐NO ☐YES

H5. PAST SURGICAL HISTORY (OPERATIONS) ☐NO ☐YES

Do not relist the cardiac operations already listed.

Example	appendectomy	YEAR; 95	Location: Medical City
1.	________	YEAR;________	Location________
2.	________	YEAR;________	Location________
3.	________	YEAR;________	Location________
4.	________	YEAR;________	Location________
5.	________	YEAR;________	Location________
6.	________	YEAR;________	Location________

SOCIAL HISTORY : **Patient Name:** **DOB:**

Marital status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you smoke cigarettes? ☐ YES ☐ NO If yes, how many? #____yrs. ____________ Packs per day

Did you ever smoke? ☐ YES ☐ NO If yes, when did you quit? ____________

Do you drink alcohol? ☐ YES ☐ NO If yes, how much? Type________ & ________ Drinks per week

Do you drink caffeine beverages? ☐ YES ☐ NO If yes, which? ______________________________

Do you use recreational drugs? ☐ YES ☐ NO If yes, which?

FAMILY HISTORY:

Relation	Age	Health Problem	Age of death	Cause
Father				
Mother				
Paternal Grand Mother				
Paternal Grand Father				
Maternal Grand mother				
Maternal Grand father				
Brother: How many in all				
Sister: How many in all				
Sons: How many in all				
Daughters: How many in all				
Any other family members with illness noted above				

VEIN SCREENING FORM
Please complete left side of form only.

Date: ____________ Appt Time: ____________ *Screening Provider:* ____________

Name: ____________ Primary Care Physician: ____________

DOB: ____________ Sex: ☐M ☐F Insurance Provider: ____________

How did you hear about us? ____________

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems ☐Y ☐N Leg: ☐R ☐L
Phlebitis (vein redness/tenderness) ☐Y ☐N Leg: ☐R ☐L
Blood clots ☐Y ☐N Leg: ☐R ☐L
Deep vein thrombosis (DVT) ☐Y ☐N Leg: ☐R ☐L
Saphenous vein reflux ☐Y ☐N Leg: ☐R ☐L

Do you experience any of the following in your leg(s):

Aching/pain ☐Y ☐N Leg: ☐R ☐L
Heaviness ☐Y ☐N Leg: ☐R ☐L
Tiredness/fatigue ☐Y ☐N Leg: ☐R ☐L
Itching/burning ☐Y ☐N Leg: ☐R ☐L
Swelling ☐Y ☐N Leg: ☐R ☐L
Cramps ☐Y ☐N Leg: ☐R ☐L
Restless legs ☐Y ☐N Leg: ☐R ☐L
Throbbing ☐Y ☐N Leg: ☐R ☐L
Skin or ulcer problems ☐Y ☐N Leg: ☐R ☐L
Other: ☐Y ☐N Leg: ☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain ☐Y ☐N What? ____________
Elevation of legs ☐Y ☐N What? ____________
Wear support hose ☐Y ☐N What? ____________

II. Family History

Have any of your family members had:

Varicose veins ☐Y ☐N Who? ____________
Vein stripping ☐Y ☐N Who? ____________
Blood coagulation disorder ☐Y ☐N Who? ____________
Blood clots ☐Y ☐N Who? ____________
Stroke, heart attacks or pulmonary emboli ☐Y ☐N Who? ____________

III. Vein Treatment History

Have you ever been treated for varicose veins with:

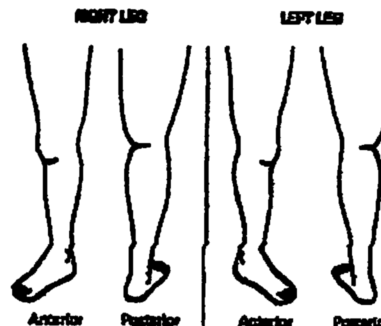
Sclerotherapy ☐Y ☐N Leg: ☐R ☐L
Laser therapy (spider veins) ☐Y ☐N Leg: ☐R ☐L
Phlebectomy ☐Y ☐N Leg: ☐R ☐L
Vein stripping surgery ☐Y ☐N Leg: ☐R ☐L
RF ablation (VNUS Closure®) ☐Y ☐N Leg: ☐R ☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods ☐Y ☐N
Prolonged sitting periods ☐Y ☐N
Do you exercise regularly? ☐Y ☐N
Do you smoke? ☐Y ☐N
Pregnancies ☐Y ☐N *How many?* ____

V. Vein Screening (to be completed by screening provider)



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

LEFT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

Clinical Assessment:

☐ Chronic venous insufficiency ☐R ☐L
☐ Other: ____________ ☐R ☐L

Treatment Plan:

☐ Duplex ultrasound ☐R ☐L
☐ Sclerotherapy ☐R ☐L
☐ Medical compression stockings ☐R ☐L
☐ Other: ____________ ☐R ☐L

Screening Provider Signature: ____________

Follow-Up Appointment
Date: ____________ Time: ____________
Physician: ____________
Physician Phone Number:

NOTES: