CardioVascular Institute of South Texas
Exceptional Heart, Vascular, & Vein Care

I. Eko Tjahja, MD, FACC
Bruce T. Kuo, MD, FACC, FSCAI
Mehdi Rambod, MD, FACC, FSCAI

PATIENT INFORMATION

PRIMARY DOCTOR:	**Phone Number:**	***Referring Doctor*:**	**Phone Number:**

Patient: Last	First	Initial	Sex	Age	Marital Status S M W D Sep	DOB: / /
Address	City	State	Zip		Home #:	Cell #:
Email:			Social Security #: - -			Driver's License #:
Employer			Occupation:			Business #:
Employer Address:			City		State	Zip
Pharmacy Name:			Pharmacy Phone #:			Pharmacy Fax #:

PERSON OR COMPANY RESPONSIBLE FOR PAYMENT:

Last Name:	First Name:	Initial	Relationship to Patient:	
Address			Home Phone #:	Social Security #: - -
City	State	Zip	Work Phone #:	Driver's License #:

IN CASE OF EMERGENCY CONTACT:

Last Name:	First Name:	Initial	Relationship:	Phone #:

HEALTH INSURANCE INFORMATION:

1st Insurance Company Name:			Name of Insured:	Social Security #:	DOB:
Send Claims To:			Employer:	Relationship to Insured: Self / Spouse / Parent / Employer / Other	
City	State	Zip	Employer Address:	Policy #:	Group #:
2nd Insurance Company Name:			Name of Insured:	Social Security #:	DOB:
Send Claims To:			Employer:	Relationship to Insured: Self / Spouse / Parent / Employer / Other	
City	State	Zip	Employer Address:	Policy #:	Group #:

All professional services rendered are charged to the patient and remain the patient's responsibility regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.
HMO & PPO PATIENTS: It is the patient's responsibility to have any required referral from the primary care doctor and to furnish complete insurance information. If the insurance information or referral is not available, the patient will be responsible for the charges and payment in full will be collected.

A $25.00 Fee will be assessed for missed appointments without a 2-hour notice.

I hereby assign payment of medical insurance benefits to the physician or physicians that rendered treatment. I understand that I am financially responsible for all charges whether or not paid by my insurance company(s). I authorize the release of medical or other information to my insurance company(s).

_____ _____
Signature of Patient or Legal Representative Date

_

I. Eko Tjahja, MD, FACC
Bruce T. Kuo, MD, FACC, FSCAI
Mehdi Rambod, MD, FACC, FSCAI

HISTORY & PHYSICAL FORM

Patient: First Initial Last	Sex	Age	Marital Status S M W D Sep	# Children	DOB: / /
Primary Care Physician Name Address City State Zip					Phone #
Reason for today's visit:					
Allergies:					
Living Arrangements: __ Home __ Independent / Assisted Living Community __ Nursing Home __ Other: _____	Exercise: __ daily __ 1-2x weekly __ 3x or more weekly __ none/never Other: _____				
Occupation:	Disabled? Yes / No	Retired? Yes / No			
Do you smoke / Have you ever? Yes / No	If yes, How many packs per day?	How long?	If yes, when did you quit?		
Do you drink / Have you ever? Yes / No	If yes, How many drinks per week?	How long?	If yes, when did you quit?		
Illegal Drugs? Yes / No List: _____	Caffeine Use: __ Coffee __ Soda __ Tea ___ Energy Drinks __ daily __ occasionally __ Quantity: _____ bottles _____ glasses				

PLEASE ANSWER THE QUESTIONS BELOW ABOUT YOURSELF:

	Y	N		Y	N
Arthritis			Liver Disease / Gallbladder Disease		
Asthma			Lung Disease		
Cancer:			Other Heart Disease		
Congestive Heart Failure			Prostate Problems (Men Only)		
COPD / Emphysema			Rheumatic Fever		
Heart Attack			Skin Disorder		
Heart Murmur			Stomach Problems or Ulcers		
Irregular Heart Rhythm			Stroke / TIA		
Kidney Disease			Urinary Problems		
Varicose Veins					

High Blood Pressure			Treated with: ○ Diet ○ Medication		
Diabetes			Treated with: ○ Diet ○ Pills ○ Insulin		
High Cholesterol Levels			Treated with: ○ Diet ○ Medication		
Angina			How is it relieved?		
Thyroid Problems			Treated with medication?	**Y**	**N**

WOMEN, PLEASE ANSWER THE FOLLOWING QUESTIONS:

	Y	N
Menopausal?		
Are you taking hormones?		
Is there a possibility that you are pregnant?		

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES?

PROCEDURES	WHERE WAS IT PERFORMED	DATE	DOCTOR WHO PERFORMED SURGERY
Heart Catheterization / Angiogram			
Angioplasty (Balloon Procedure) / Stent			
Heart or Valve Surgery			
Carotid Endarterectomy			
Femoral Popliteal Bypass			
Pacemaker			
Implanted Defibrillator			
Echocardiogram			
Treadmill Test			
24 Hour Heart Monitor			

- ***PLEASE PROVIDE A COPY OF YOUR PACEMAKER, VALVE, OR ICD CARD TO OUR RECEPTIONIST.***

PLEASE LIST ANY SURGERIES YOU HAVE HAD THAT ARE NOT LISTED ABOVE:

SURGERY	PLACE IT WAS PERFORMED	DATE	DOCTOR WHO PERFORMED SURGERY

	Y	N	
Do you exercise?			What type?
			How often?

When was the last time you checked your cholesterol level?	

HAVE YOU HAD ANY OF THESE MEDICAL SYMPTOMS / CONDITIONS WITHIN THE PAST 3 MONTHS:

	Y	N		Y	N		Y	N
Pain with breathing			Shortness of breath			Hepatitis		
Headaches			Unusual fatigue			HIV positive		
Episodes of fainting			Palpitations			Feeling light-headed / Dizzy		
Anxiety / Depression			Swelling in legs / ankles			Clots in lungs		
Chest Pain / Pressure			Unusual sweating			Heartburn		
Numbness / Tingling			rapid heart rate					

Have you had chemical exposure that may be harmful to your health?	

How many pillows do you sleep on?	

	Y	N		Y	N		Y	N
Do you awaken breathless at night?			Do you snore?			Do you fall asleep easily during the day?		

HISTORY OF IMMEDIATE FAMILY ILLNESS. PLEASE CIRCLE "Y" FOR YES "N" FOR NO:

	MOTHER			FATHER			SISTER(S)			BROTHER(S)	
Cancer	Y	N		Y	N		Y	N		Y	N
Diabetes	Y	N		Y	N		Y	N		Y	N
Heart Attack	Y	N		Y	N		Y	N		Y	N
High Blood Pressure	Y	N		Y	N		Y	N		Y	N
High Cholesterol	Y	N		Y	N		Y	N		Y	N
Stroke	Y	N		Y	N		Y	N		Y	N
Living?	Y	N		Y	N		Y	N		Y	N
Cause of death, if applicable											

Medication List

Name of Medication	Dosage(s)	Frequency

Imam Tjahja, MD, FACC
Bruce Kuo, MC, FACC, FSCAI
Mehdi Rambod, MD, FACC, FSCAI

Communication Authorization and Designated Party Release

You may give Cardiovascular Institute of South Texas, written authorization to disclose your protected health information to anyone that you designate such as a family member or personal representative. If you wish to authorize a person/persons to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detail information (results of labs, prescription refills, etc.) on your home answering machine, voicemail at work, cellphone or to another party that you designated.

Patient Name: _____ DOB: _____

Today's Date: _____ Acct#: _____

I authorize Cardiovascular Institute of South Texas to disclose my protected health information to: (***write name of person/persons who you want to receive your personal health information):***

Name(s): _____

Phone Number(s): _____

Relationship to Patient: _____

At my request, I also authorize Cardiovascular Institute of South Texas to communicate my protected health information to me via the following methods:

☐ Home Telephone _____
- ☐ O.K. to leave messages with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. To mail to my home address
- ☐ O.K. To mail to my work/office address
- ☐ O.K. To fax to this number _____

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other: _____
_____

☐ Cell Phone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Authorized Signature: _____ Date: _____

I understand that I may cancel this authorization at any time by signing this notice below or providing written cancellation. However, if I cancel this authorization. I also understand that the cancellation will ***not*** affect any action Cardiovascular Institute of South Texas took in reliance on this authorization before receipt of this notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: _____

I. Eko Tjahja, MD, FACC
Bruce T. Kuo, MD, FACC, FSCAI
Mehdi Rambod, MD, FACC, FSCAI

CONSENT TO TREATMENT AND CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the patient identified below, or his or her legal guardian or representative, request and consent to the procedure and treatment that may be performed by physicians and other clinical staff of Cardiovascular Institute of South Texas, and which may include but are limited to physical examinations, laboratory procedure, diagnostic procedures, and medical treatment or procedures rendered for the patient under general and special instructions of the patient's physician.

I understand that as part of my healthcare, the Association originates and maintains records that may include my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment, and information payment for the provision of health services, I understand and authorize this information to be utilized to plan my care and treatment, to bill for services provided to me, to communicate with
other healthcare providers and other healthcare operations including quality assessment through outcomes evaluations and development of clinical guidelines; reviewing competence of healthcare professionals through
peer review and credentialing activities; and conducting fraud and abuse and compliance reviews. I further understand that all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I understand that I may revoke this consent at any time in writing except that the Association has already acted in reliance on this consent. I also understand that this consent is valid until revoked by me in writing.

_____ _____

Print Patient Name or Legal Representative Date

_____

Patient Signature or Legal Representative

Notice Concerning Complaints
Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants
and acupuncturists, may be reported for investigation at one of the following addresses:

Texas State Board of Medical Examiners Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2918	**Cardiovascular Institute of South Texas** Privacy Officer: HIPPA OFFICER 12340 Bandera Rd., Suite 104 Helotes, Texas 78023 Phone: (210) 920-8000

Assistance in filling a complaint is available by calling the following telephone number: **1-800-201-9353**

Cardiovascular Institute of South Texas Financial Policy

Thank you for choosing Cardiovascular Institute of South Texas. We are committed to providing you with quality and affordable health care. Our practice financial policy is as followed:

_____ **Insurance:** We bill participating insurance companies as a courtesy to you. If you **are not** insured by a plan we do business with, payment in full is required at each visit. If you **are** insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage. By signing this form, you authorize CVISTX to release the necessary information in order to complete and process your insurance claims.

_____ **Co-Pays, Co-Insurance & Deductibles:** All co-payments, co-insurance, and deductibles must be paid at the time of service. We cannot bill for co-pays. The arrangement is part of your contract with your insurance company and federally mandated. CVISTX accepts cash, checks (in state), and major credit cards. You will be expected to pay your balance in full at the time of your appointment unless prior payment arrangements have been made. A $25 Non-sufficient funds (**NSF**) fee will be assessed for any returned checks.

_____ **Managed Care:** If you are enrolled in a managed care insurance plan (i,e. HMO) we must receive a referral prior to your scheduled appointment. If you chose to be seen without a referral, you will be scheduled as a private pay patient and payment will be due in full at the time of service.

_____ **Updates:** Our staff will ask you to verify your billing information at every visit. Current information is essential for us to contact you regarding your treatment and for obtaining timely payments from your insurance company.

_____ **Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner. Please be aware that the balance of your claim is your responsibility. If your insurance company does not pay your claim within 60 days, you may be expected to pay the balance in full.

_____ **Forms Fee:** There will be a **$25.00** fee for completion of Disability, FMLA, and Insurance forms. For Medical Records requests, there is a fee of **$25.00** for the first 25 pages and 10 cents per page thereafter.

_____ **Coverage Changes:** If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits.

_____ **Non-Payment:** Payment is due at time of service unless prior arrangements have been made. Patients with outstanding balances of 60 days or more must make payment arrangements prior to scheduling appointments. Accounts overdue 90 days or more will be forward to an outside collection agency. Accounts sent to an outside collection agency will have a 30% service fee added to the account.

_____ **Missed Appointments:** Missed appointments represent a cost to us, to you, and to the other patients who could have been seen in the time set aside for you. Cancellations are to be made 24 hours prior to the appointment. **We will charge a $25.00 fee for missed or canceled appointments with less than 24 hours' notice.**

_____ **Refunds:** Patient/Guarantor credits will be retained on account to be credited towards future balances unless a written request for a refund is received.

I have read and understand Cardiovascular Institute of South Texas' payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Legal Representative Date

If you have questions or need assistance, please contact our office at (210) 920-8000.
Our business hours are 8:30am to 5:00pm CST, Monday through Friday.

CardioVascular Institute of South Texas
Exceptional Heart, Vascular, & Vein Care

I. Eko Tjahja, MD, FACC
Bruce T. Kuo, MD, FACC, FSCAI
Mehdi Rambod, MD, FACC, FSCAI

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and explains how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about your treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and those revised policies will apply to all the protected health information we maintain. If, or when we change our notices, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment:

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to that physician, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment:

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operation:

We are permitted to use or disclose your medical information for the purpose of health care operations, which are activities that support this practice and ensure that quality care is delivered. Examples include, "we may engage the services of a professional to aid this practice in its compliance program. This person will review billing and medical files to ensure we maintain our compliance with current regulations and the law." Or "We may also ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best healthcare." For further information on "healthcare operations" see the definition in the regulation at 45 CFR 164.501. A link to the regulation is available on the TMA website.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that apply on that authorization.

_____ _____

Signature of Patient or Legal Representative Date

Phone: (210) 920-8000
Fax: (210) 920-6000
Web:http://www.cvistx.com

12340 Bandera Road, Suite 104
Helotes, Texas 78023

151 Medical Drive
Pearsall, Texas 78061

I. Eko Tjahja, MD, FACC
Bruce T. Kuo, MD, FACC, FSCAI
Mehdi Rambod, MD, FACC, FSCAI

AUTHORIZATION AND INFORMED CONSENT TO OBTAIN MEDICAL RECORDS INFORMATION

Today's Date: _____

Medical Records Requested From:

_____

_____

_____

Patient's Full Name: _____ D.O.B _____

Patient's Phone#: _____ SSN#: _____

Name of Person or Organization to receive the Medical Records Information:

CARDIOVASCULAR INSTITUTE OF SOUTH TEXAS
12340 BANDERA RD, SUITE 104
HELOTES, TEXAS 78023
PHONE: (210) 920-8000
FAX: (210) 920-6000

Please release the following records:

_____ Full Medical Records

_____ Medical Records from _____ to _____

_____ Other _____

I authorize and give my consent to _____, to release the above- stated information to the identified person or organization. This authorization is to remain in effect for one year from the date of signature.
I understand I may revoke this authorization at any time by providing the revocation request in writing. I also understand that the revocation will not affect any action taken in reliance on this authorization before receipt of the notice.

_____ _____
Date Patient's Signature