NORTHWEST HOUSTON HEART CENTER

PATIENT FINANCIAL POLICY AND CONSENT FORM

Patient Financial Policy

We are dedicated to provide the best possible care and service to our patients. To avoid confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager.

Fees and Payments

We share your concerns about rising health care costs. Our fees represent usual and customary charges based on community standards. Patients are expected to pay for professional services at the time of the visit. Our policy is to collect the co-payment when you arrive for your appointment. All forms of payment are accepted including cash, personal checks, debit cards and credit cards including MasterCard, Visa, American Express, and Discover. If you have any questions about our fees, please feel free to discuss with us.

Insurance

We have a contract with many health plans to accept an assignment of benefits. We will bill these plans and will require the patient to pay authorized co-payments, coinsurance, and deductibles at the time the services are rendered. The responsibility for payment of medical care costs is the direct responsibility of the patient. The remaining balance is due within one month of notice from the insurer. The patient is responsible for obtaining authorization from his or her primary care physician. The patient is responsible for understanding the authorization process and the payment process of his or her insurance company.

Physician Authorization and Assignment of Benefits

I hereby authorize Northwest Houston Heart Center to release any medical information and diagnosis requested by my insurance company and my treating physicians. I understand that this information will include, where applicable, all the work up, testing, diagnosis and treatment. Treatment plans also including all blood work and specific laboratory test results including HIV testing for the diagnosis of acquired immune deficiency syndrome. I further authorize payment directly to the assigned physician for the surgical and or medical payables under my plan for services provide to me.

Authorization to Release Medical Records

I am writing to authorize Northwest Houston Heart Center to obtain my medical records on my behalf. Please send my medical records by fax at 281-351-4915 or by mail at the following address: 308 Holderrieth Blvd Tomball, TX 77375-4536

Advance Beneficiary Notice of Noncoverage (ABN)

You are receiving this notice because your insurance company may not pay for all the services that you receive during your visits to our office. You need to read this notice so that you can make an informed decision about your care. If your insurance carrier denies payment, then you are completely responsible for payment in full to the services rendered to you at this facility., You understand that you can appeal this decision for nonpayment to your insurance carrier. By this notice, you agree to take financial responsibility for the cost of the supplies and services rendered to you at your visit to our facility, if your insurance company denies coverage for the same. If you do not want any service not covered by your insurance company, please inform us in writing at the time of check in.

Print Name _____ Date _____

Patient Signature_____ Date _____

Witness Signature _____ Date _____

308 Holderrieth Blvd
Tomball, TX 77375

18230 FM 1488
Magnolia, TX 77354

21216 NW Fwy Ste 640
Cypress, TX 77429

Phone: 281-351-4911 ● Fax: 281-351-4915 ● www.houstonheartcenter.com

NORTHWEST HOUSTON HEART CENTER

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL RECORDS

Authorization to release medical records for _____
Name

DOB:_____ SSN_____

I authorize **Northwest Houston Heart Center** to release to and receive my medical records from my current and past treating physicians.

Name_____

Phone_____ Fax_____

This information is being released for the following purpose:

☐ Continued Care ☐ Insurance ☐ Attorney/Litigation ☐ Disability Services

☐ Other _____

PLEASE FAX RECORDS TO (281)351-4915

_____ _____
Signature of Patient or Legally Authorized Representative Date

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it

Date _____

Name _____ DOB_____
Last First Middle

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment plans, payments, and health care operations)

Name_____ **Relation** ☐ Spouse ☐ Child ☐ Other _____

Contact Ph#_____

Name_____ **Relation** ☐ Spouse ☐ Child ☐ Other _____

Contact Ph#_____

Name_____ **Relation** ☐ Spouse ☐ Child ☐ Other _____

Contact Ph#_____

Could confidential messages, i.e., appointment reminders, lab results, or any health care information be left on your voicemail? ☐ Yes ☐ No

Patient Signature _____ Date _____

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INSURANCE INFORMATION

Do you have Medicare? ☐ Yes ☐ No **If yes, your Medicare ID#** _____

Primary Insurance Name_____ **Policy Holder**_____

Relation ☐ Self ☐ Spouse ☐ Other **ID#**_____ **Group#**_____

Secondary Insurance Name_____ **Policy Holder**_____

Relation ☐ Self ☐ Spouse ☐ Other **ID#**_____ **Group#**_____

PATIENT DEMOGRAPHICS

Name _____ **DOB** _____ **Age** _____
Last First Middle

SSN _____ **Gender** ☐ Male ☐ Female **Status** ☐ Single ☐ Married ☐ Other _____

Race/Ethnicity ☐ White ☐ Hispanic ☐ Black/African American ☐ Asian ☐ Other _____

Address _____ **City** _____ **State**_____ **Zip**_____

Home #_____ **Cell #** _____ **Work#** _____

Email _____

Occupation _____

Emergency Contact _____ **Relation**_____ **PH#** _____

Primary Care Physician: _____

Referring Doctor (if applicable): _____

Reason for your visit? _____

_____

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PAST MEDICAL HISTORY	PATIENT HISTORY	FAMILY HISTORY
Coronary Artery Disease	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Heart Attack	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Cardiac Arrest	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Angioplasty/Stent of heart arteries	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Coronary Artery Bypass	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Peripheral Vascular Disease (PAD/PVD)	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Abdominal Aortic Aneurysm	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Stroke	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Atrial Fibrillation/Atrial Flutter	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Diabetes	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
High Cholesterol	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
High Blood Pressure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Pacemaker Placement	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Defibrillator Placement	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Congestive Heart Failure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____
Kidney/Renal Problems	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No Relation_____

Patient Name (please print) _____

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Social History
Are you married? ☐ Yes ☐ No
Do you currently smoke? ☐ Yes ☐ No How many cigarettes per day? _____
Have you ever been a smoker? ☐ Yes ☐ No How many per day?_____ How long?_____
Do you currently drink alcohol? ☐ Yes ☐ No How much?_____ How often?_____
Do you use recreational drugs? ☐ Yes ☐ No

Check all that apply (Review of Systems)	
Constitutional	☐ Weight gain ☐ Weight loss ☐ Snoring
Ophthalmology	☐ Double vision ☐ Blurring of vision ☐ Vision loss
ENT	☐ Dizziness ☐ Allergies ☐ Sore throat
Cardiology	☐ Chest pain ☐ Palpitations ☐ Heart murmur ☐ Syncope/Passing out ☐ Excessive Fatigue
Respiratory	☐ Shortness of breath ☐ Asthma
Gastroenterology	☐ Polyps ☐ Colitis ☐ Ulcers ☐ Liver disease
GU	☐ Kidney disease ☐ Bladder problems
Musculoskeletal	☐ Knee Pain ☐ Ankle pain ☐ Hip pain ☐ Leg cramps
Psychiatrics	☐ High stress level ☐ Depression ☐ Sleep disturbances ☐ Anxiety
Endocrinology	☐ Weight loss ☐ Diabetes ☐ Thyroid abnormalities
Neurology	☐ Headache ☐ Tingling/Numbness ☐ Seizures ☐ Memory loss
Dermatology	☐ Rash ☐ Frequent bruising ☐ Ulcer/Sores on legs or feet

CIRCULATION QUESTIONNAIRE

Vein circulation questions	
Are your legs swollen?	☐ Yes ☐ No
Have you had a blood clot in the past?	☐ Yes ☐ No
Do you have varicose veins (veins that are enlarged/swollen and raised) in the legs?	☐ Yes ☐ No
Do your legs feel heavy, tired, restless, or achy?	☐ Yes ☐ No
If you push on your swollen foot, ankle, or leg for 10 seconds and release, does it leave a dimple?	☐ Yes ☐ No
Do you have an ulcer on the inside of your leg or ankle?	☐ Yes ☐ No

Arterial Circulation questions	
Do you have foot/calf/buttock/thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	☐ Yes ☐ No
Do you experience any pain at rest in your lower leg(s) or feet?	☐ Yes ☐ No
Do you experience foot or toe pain that often disturbs your sleep?	☐ Yes ☐ No
Are your toes or feet discolored, or bluish?	☐ Yes ☐ No
Do you have skin wounds or ulcers on your feet or toes that are slow to heal?	☐ Yes ☐ No
Have you suffered a severe injury to the leg(s) or feet?	☐ Yes ☐ No
Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	☐ Yes ☐ No

NORTHWEST HOUSTON HEART CENTER

Current Medications with Dosages Please enlist them here or give them to staff when you get into exam room
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

Recent Hospitalization in the last 3 months? ☐ Yes ☐ No

If yes, please specify when/where/and reason _____

_____

Allergies to any medications? ☐ Yes ☐ No

If yes, please list the name of medication(s) and type of reaction _____

_____

Allergy to Iodine Dye? ☐ Yes ☐ No

This dye is generally given during Angiogram or CT scan

If yes, please describe kind of reaction _____

_____

Patient Signature _____ Date _____

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