The Woodlands
Heart & Vascular Center

Patient Name:_____ DOB:_____MRN:_____

Instructions During COVID

1. Do you have or have you had a temperature of 100.1 or above within the last 2 weeks? Yes or NO
2. Do you have any of the following symptoms….
    a. Recent/ New onset of coughing? (not related to COPD) Yes or NO
    b. Nasal Congestion? (not related to allergies or sinus infection) Yes or No
    c. Recent/ New onset of a sore throat? Yes or NO
    d. Recent/ New Onset of shortness of breath? (not related to chronic disease) Yes or NO
    e. Recent/ New onset of diarrhea? Yes or NO
3. Are you living with someone that is quarantined or furloughed? Yes or NO
4. Have you been in contact with an individual positive for covid-19? Yes or NO
5. Have you been in contact with an individual suspected for covid-19? Yes or No
6. Have you travelled within the last 14 days outside the city? If you live outside the City where have you been? Yes or No

All patients are to call the office at 281-606-5355 to check -in via phone and wait in their vehicles until we call them and ask them to enter the premises. We are sorry for the inconvenience; we will always need a good cell phone number to reach them.

Print: _____

Sign: _____ Date: _____

The Woodlands
Heart & Vascular Center

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

email: _____@_____._____

Name (*First, M.I., Last)*_____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Address _____

Phone Number _____ S.S.N. # _____ D.L. #_____

Employer _____ Phone _____

Employer Address _____

Referring Physician _____ Phone _____ Fax _____

Pharmacy _____ Phone _____

Emergency Contact _____ Phone _____

Language _____ Ethnicity (Circle One) Latino / Not Latino / No Reply

Race (Circle One) African American / Asian / White / Decline to Specify

Insurance Information

Primary Insurance _____ Phone _____

Policy # _____ Group # _____ Effective Date _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Secondary Insurance _____ Phone _____

Policy # _____ Group # _____ Effective Date _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

I hereby authorize *The Woodlands Heart and Vascular Center* to apply for benefits on my behalf for covered services rendered by the physician. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I authorize the release of any medical information needed to process this claim and all future claims. I permit a copy of this authorization to be used in place of the original. I authorize that payment from my insurance company be made directly to *The Woodlands Heart and Vascular Center*. I also authorize consent for treatment of any and all medical services performed. This authorization will remain valid until I revoke it by written notice.

Patient Signature _____ Date _____

The Woodlands
Heart & Vascular Center

New Patient Paperwork

Patient Name:_____ **D.O. B:**_____ **MRN#:**_____

Primary/Referring Provider:_____ **Phone Number:** _____

Reason for Visit: _____

MEDICATION LIST

***** PLEASE LIST ALL MEDICATIONS & SUPPLEMENTS EVEN IF THEY ARE NOT CARDIAC MEDICATIONS OR AS NEEDED, THIS IS VERY IMPORTANT TO ADD*****

Name of Medication	Dose	Directions/Reason for medication	Prescribing Doctor

_____ _____

Signature Date

The Woodlands
Heart & Vascular Center

Medical History: ***(Please Remember to list all medical history not just cardiac history)***		
☐ Heart attack	☐ Heart Murmur	☐ Thyroid Disease
☐ Stroke	☐ High Blood Pressure	☐ Cancer: _____
☐ Aneurysm	☐ Low Blood Pressure	☐ Epilepsy/Seizures
☐ Shortness of Breath	☐ Diabetes	☐ Anemia
☐ Congenital Heart Disease	☐ Elevated Cholesterol	☐ Bleeding Problems
☐ Congestive Heart Failure	☐ Stress	☐ Eye Problems
☐ Irregular Heart Rhythm	☐ Kidney Disease	☐ Weight loss
☐ Headaches/Migraines	☐ Pulmonary Disease	☐ Gastrointestinal Problems
☐ Frequent Urination	☐ Dizziness	☐ Rheumatic Fever
☐ Depression	☐ Palpitations	☐ Chest Pain
☐ Anxiety	☐ Fainting	☐ Leg pain/swelling
☐ Blood Clots	☐ Varicose Veins	☐ Fatigue
If not listed above, please list any other medical history below:		

Cardiac Questions

Have you ever had any of the following testing?

- ☐ **Bypass Surgery? When and Where: _____**
- ☐ **Angioplasty/Stents? When and Where: _____**
- ☐ **Stress Test? When and Where: _____**
- ☐ **Echo Cardiogram (ultrasound)? When and Where: _____**
- ☐ **ECG (Electrocardiogram) EKG? When and Where: _____**

Medication Allergies

Name of Medication	Symptoms/Reaction	How Severe

The Woodlands
Heart & Vascular Center

Surgical History

Procedure	Name of Facility/Hospital	Date of Procedure

Hospital/Emergency Room Visit

Name of Hospital/Location	Reason	Date (month/year)

Family History

Relation & Age	Living	Deceased	Health History	Cont.	Other:
Father- Age:			☐ Heart Disease/ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure	☐ Diabetes ☐ Heart Failure ☐ Stroke/TIA	
Mother- Age:			☐ Heart Disease/ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure	☐ Diabetes ☐ Heart Failure ☐ Stroke/TIA	
Son(s): How many?: Ages:			☐ Heart Disease/ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure	☐ Diabetes ☐ Heart Failure ☐ Stroke/TIA	
Daughter(s): How many?: Ages:			☐ Heart Disease/ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure	☐ Diabetes ☐ Heart Failure ☐ Stroke/TIA	
Paternal Grandfather Age:			☐ Heart Disease/ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure	☐ Diabetes ☐ Heart Failure ☐ Stroke/TIA	
Paternal Grandmother Age:			☐ Heart Disease/ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure	☐ Diabetes ☐ Heart Failure ☐ Stroke/TIA	
Maternal Grandfather Age:			☐ Heart Disease/ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure	☐ Diabetes ☐ Heart Failure ☐ Stroke/TIA	
Maternal Grandmother Age:			☐ Heart Disease/ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure	☐ Diabetes ☐ Heart Failure ☐ Stroke/TIA	

(Please remember to list all History, not just cardiac history)

The Woodlands
Heart & Vascular Center

Social History

Alcohol use:

In the past year have you had a drink containing alcohol?

- ☐ Yes
- ☐ No

If yes, how often did you have a drink containing alcohol in the past year?

- ☐ Never
- ☐ Monthly or less
- ☐ 2 to 4 times a month
- ☐ 2 to 3 times a week
- ☐ 4 or more times a week

If yes, how many drinks did you have on a typical DAY when you were drinking in the past year?

- ☐ 1 or 2 drinks
- ☐ 3 or 4 drinks
- ☐ 5 or 6 drinks
- ☐ 7 to 9 drinks
- ☐ 10 or more drinks

If yes, how often did you have 6 or more drink on one occasion in the past year?

- ☐ Never
- ☐ Less than Monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Tobacco Use

Are you a:

- ☐ Current Smoker
- ☐ Former Smoker
- ☐ NON- Smoker
- ☐ Other forms of Tobacco

Source of Tobacco:

- ☐ Very Heavy Cigarette Smoker (40+ cigs daily)
- ☐ Heavy Cigarette Smoker (20-39 cigs/day)
- ☐ Moderate Cigarette Smoker (10-19 cigs/day)
- ☐ Light Cigarette Smoker (1-9 cigs/day)
- ☐ Chewing Tobacco? How much:_____cans day/week/month
- ☐ Cigars?_____daily/week/month
- ☐ E-Cigarette

If smoking/chewing tobacco are you interested in quitting?

☐ Yes ☐ Thinking about quitting

☐ Not at this time

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Have you in the past or do you currently do any of the drugs listed below?

- ☐ Heroin: **yes no past** if yes or past, last time used: _____
- ☐ Cocaine: **yes no past** if yes or past, last time used: _____
- ☐ PCP: **yes no past** if yes or past, last time used: _____
- ☐ Ketamine: **yes no past** if yes or past, last time used: _____
- ☐ Marijuana: **yes no past** if yes or past, last time used: _____
- ☐ Ecstacy: **yes no past** if yes or past, last time used: _____
- ☐ LSD: **yes no past** if yes or past, last time used: _____
- ☐ Crack: **yes no past** if yes or past, last time used: _____
- ☐ Methamphetamine: **yes no past** if yes or past, last time used: _____
- ☐ Prescription opiates: **yes no past** if yes or past, last time used: _____

Do you drink Caffeine?

- ☐ **Coffee: _____cups daily**
- ☐ **Soda: _____ per day**
- ☐ **Tea: _____ per day**
- ☐ **Energy Drink: _____ per day**
- ☐ **None**

Do you Exercise? (if yes, how much and type of exercise?)

- ☐ **Daily -_____How long?:_____ hr./min**
- ☐ **1-2 times weekly-_____How long? :_____hr./min**
- ☐ **2-4 times weekly-_____How long? :_____hr./min**
- ☐ **4-6 times weekly-_____How long? :_____hr./min**
- ☐ **NEVER**

By Signing this completed form I am confirming I have read over and answered all medical history questions to the best of my knowledge and give The Woodlands Heart and Vascular Center Permission to use the information I have provided to add it into my medical records on file.

Patient Signature: X _____ **Date:** _____

The Woodlands
Heart & Vascular Center

VEIN SCREENING ASSESSMENT

Name:		Date:
Phone:		E-mail:
Primary Insurance:		Secondary Insurance:
Sex ☐ M ☐ F	Date of Birth:	How did you hear about us?

HISTORY

Have you ever had varicose veins or bulging veins? ☐ Yes ☐ No

SIGNS AND SYMPTOMS

Do you experience **ANY** of the following in your legs or ankles?

- ☐ Leg pain, aching or cramping
- ☐ Burning or itching of the skin
- ☐ Leg or ankle swelling, especially at the end of the day
- ☐ "Heavy" feeling in legs
- ☐ Varicose veins
- ☐ Skin discoloration or texture changes, such as above the inner ankle
- ☐ Open wounds or sores, such as above the inner ankle
- ☐ Restless legs

RISK FACTORS

Has anyone in your family ever had varicose veins/ blood clots? ☐ Yes ☐ No
Have you had any treatments or procedures for vein problems? ☐ Yes ☐ No
Do you sit or stand for long periods of time, such as at work? ☐ Yes ☐ No
Do you frequently engage in heavy lifting? ☐ Yes ☐ No
Have you been pregnant? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No

Additional Notes

_____

_____

Print Name:_____ Patient Signature:_____

The Woodlands
Heart & Vascular Center

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used:_____Date of Birth: _____

Address:_____City:_____State:_____Zip Code:_____

Phone: (_____)_____Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name:_____

Address:_____City:_____State:_____Zip Code:_____

Phone: (_____)_____Fax: (_____)_____

Information regarding person or entity who can receive and use this information:

Name: The Woodlands Heart & Vascular Center (Office of Jasmine R Khan MD PA)

Address: 128 Vision Park Blvd Ste 145 City: Shenandoah State: TX Zip Code: 77384

Phone: (281) 606 - 5355 Fax: (844) 684 - 4234

Specific information to be disclosed:

□ Medical Record from (insert date)_____to (insert date) _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

The Woodlands
Heart & Vascular Center

Include: (*Indicate by Initialing*)	**Reason for release of information:**
_____Drug, Alcohol or Substance Abuse Records	***(Choose all that Apply)***
_____Mental Health Records (Except Psychotherapy Notes)	□ Treatment/Continuing Medical Care
_____HIV/AIDS-Related Information (Including HIV/AIDS Test Results)	□ Personal Use □ Billing or Claims
_____Genetic Information (Including Genetic Test Results)	□ Insurance □ Legal Purposes
	□ Disability Determination
	□ School □ Employment
	□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day:_____Year:_____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative:_____Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional):_____ Date:_____

The Woodlands
Heart & Vascular Center

FINANCIAL POLICY

I understand that I am financially responsible for all charges (deductibles, copayments and/or coinsurances, non-covered services) whether or not they are covered by insurance and all payments are to be made directly to *The Woodlands Heart and Vascular Center*. It is also my responsibility to provide the most current insurance information so that claims can be processed in a timely manner. All balances due after the processing and/or payment of claims are payable within 30 days. If the balance cannot be paid in full at that time, please call and make payment arrangements. If no payment is received and the account remains delinquent after 90 days, it will be placed in collection status. I understand that I will be legally responsible for all collection costs involved with this account, including court costs, attorney fees, and all other expenses incurred with collection.

The Woodlands Heart and Vascular Center is mandated to provide the information you need to understand every aspect of your healthcare. In keeping with this promise, as well as compliance with the state and federal laws, you are provided with this list of office fees that are not covered under your insurance plan, effective February 1, 2017.

- No Show Office Visit (unless 24hr advance notice* is given) - $35.00
- No Show Echo/Ultrasound (unless 24hr advance notice* is given) - $35.00
- No Show Nuclear Stress Test (unless 48hr advance notice* is given) - $250.00
- No Show Vein Ablation (unless 48hr advance notice* is given) - $200.00
- Medical records – 1-20 pages $25.00, each additional page $0.50
- Prior Authorization for Medications - $10.00 per authorization, max $50.00 per year
- All forms filled out by MD/Staff - $15.00 per form
- Late Payment - $25.00

*advance notice can only be given on business days during work hours.

I have read the above description of the financial policy and agree to what it says.

Patient Name: _____ Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____

If Legal Representative, relationship to Patient: _____

The Woodlands
Heart & Vascular Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

EFFECTIVE February 1, 2017

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to The Woodlands Heart and Vascular Center, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel providing or involved in providing health care to you (both within and outside of the Practice).

B. For Payment. We may use and disclose medical information about you so that we may bill and collect from you, an insurance company, or a third party for the health care services we provide and obtain prior authorization for treatment and procedures from your insurance plan.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations necessary to operate and manage our practice and to promote quality care.

D. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, to contact you (including, for example, contacting you by phone and leaving

a message on an answering machine; email reminders), to provide appointment reminders and to tell you about health-related benefits or services that we believe may be of interest to you.

E. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates.

F. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law, or in accordance with your prior authorization.

G. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

H. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of anotherperson.

I. Workers' Compensation. We may disclose medical information about you as required by your workers' compensation program.

J. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. The types of information generally include informationused:

- To report births and deaths.
- To report reactions to medications or problems with medical devices and supplies.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

K. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. We are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided toyou.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession. If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may deny your request if you ask us to amend information that (i) was not created by us (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing thelist.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations and to someone who is involved in your care or the payment for your care. We are not required to agree to your request for a restriction or limitation.

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at anytime.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you(and potentially other parties) if we become aware that your medical information has been improperly disclosed or subject to a “breach” as defined in and/or required by HIPAA and applicable statelaw.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

The Woodlands Heart and Vascular Center
Attn: HIPAA Officer
128 Vision Park Blvd, Ste 145, Shenandoah, TX 77384
(281) 606-5355

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

Patient Name: _____ Patient Date of Birth: _____

(Please Print Name)

SIGNATURES:

Patient/Legal Representative:_____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) :_____ Date:_____