100 Medical Center Blvd., Suite 200, Conroe, Tx 77304

129 Vision Park Blvd., Suite 306, Shenandoah, TX 77384

Phone: (936) 441-9680 Fax: (936) 539-9685

Thank you for choosing Healing Hearts for your cardiology needs.
Our providers are Dr. Afzal; Dr. Yamani; Dr. Banerjee; Dr. Desai

Please complete the attached forms; as well as follow the listed instructions to ensure no delay in your appointment:

- All paperwork **MUST** be returned to our office 48 hours **BEFORE** the visit – **no exceptions**! If we do not have your paperwork prior, your appointment will be rescheduled.

- Please bring originals of your insurance and driver's license so we may scan a copy.

- It is **YOUR** responsibility to make sure that your **prior medical records** (cardiac in nature) are either sent to our office by fax, or you may hand carry them in **one week before** your visit.

- Bring all your medications with you (including supplements) to your appointment.

- If your insurance requires a **referral from your primary physician**, **it is your responsibility** to make sure and have it faxed to our office before your appointment; or you may hand carry it to your appointment.

HEALING HEARTS

REGISTRATION FORM - (PLEASE PRINT)

Date: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Marital status (mark one) ❑Single ❑ Mar ❑ Div ❑Sep ❑ Wid

Birth date: _____ Sex: ❑ M ❑ F

Race: _____ Ethnicity: _____

Preferred Language: _____

Email: _____

Interpreter Needed: ❑ Yes ❑ No

Street address: _____ Social Security: _____

Home ph: _____

City: _____ State: _____ ZIP Code: _____

Cell ph: _____

Employment Status: ❑ Full Time ❑ Part Time ❑Unemployed ❑ Student ❑ Other: _____

Pharmacy's Name _____

Pharmacy's Ph: (_____) _____

Primary Doctor (PCP) Last name: _____ First: _____ PCP Ph: _____

INSURANCE INFORMATION (Please bring your insurance card & ID to the receptionist)

PRIMARY INSURANCE

Name of primary insurance: _____

Subscriber's name: _____

Birth date: _____

Group: _____

Policy#: _____

Patient's relationship to subscriber:
❑ Self ❑ Spouse ❑ Other

SECONDARY INSURANCE

Name of Secondary insurance: _____

Subscriber's name: _____

Birth date: _____

Group: _____

Policy#: _____

Patient's relationship to subscriber:
❑ Self ❑ Spouse ❑ Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of financial policy, and privacy policies and practices of this clinic.

_____ _____

Patient Signature *Date*

HEALING HEARTS PATIENT PRIVACY NOTICE SUMMARY

Protecting your confidential health information is important to us. Certain federal law referred to as "**HIPAA**" protects the confidentiality of your health information (generally referred to as "**Protected Health Information**" or "**PHI**"), and we take it seriously. This summary of our **Notice of Privacy Practices** ("**Notice"** or **"Privacy Notice"**) has been prepared to provide you with a brief description of certain of the key provisions of the Notice regarding how medical and other personal information about you may be used or disclosed, and how you may obtain access to your information and its disclosure. For a more complete description of our privacy practices under HIPAA, please refer to the attached Notice.

What is Protected Health Information (PHI)?

PHI is information created or received by Healing Hearts and transmitted or maintained in written, electronic or any other form, that relates to your past, present or future health condition, the provision of healthcare to you, and/or information about payment for the provision of your healthcare, and, which may identify you or could reasonably be used to identify you.

How may my PHI be used or disclosed?

Healing Hearts may use or disclose your PHI to carry out your **'Treatment'** (provision, coordination or management of your healthcare or related services), **'Payment'** (obtain payment for your healthcare services, including activities that may be required by your insurer(s) to obtain approval for payment), or for other **'Health Care Operations'** (other functions that Healing Hearts performs in connection with providing health care, i.e., quality assessments, training of medical students, credentialing, auditing and financial reporting). Use or disclosure of your PHI pursuant to the Notice may include electronic transmittal or disclosure. Healing Hearts also sends PHI to a Health Information Exchange (HIE) to allow for information exchange for information that may be relevant to your future care i.e. in an emergency situation participating facilities and physicians can access your information for your treatment. In addition, your prior prescription information will be obtained through SureScripts to assist us in providing you treatment. You can opt out of the HIE and of SureScripts by completing the appropriate forms available when you ask your Healing Hearts office staff.

When might Healing Hearts use or disclose my PHI without my authorization?

Healing Hearts is not required to obtain your authorization or notify you when it uses or discloses your PHI for your treatment, to obtain payment, or for other health care operations as discussed above. In addition, there are some limited exceptions where the law allows your PHI to be used to promote the Government's need to ensure a safe and healthy society. In some cases, you may be given an opportunity to agree or object before the use or disclosure of your PHI. In all cases, Healing Hearts will make every effort to ensure that it meets necessary prerequisites and will not use or disclose your PHI more than is permitted under the law.

What Are My Rights Under the HIPAA Privacy Standards?

Patients have certain rights under the HIPAA Privacy Standards, subject to certain limitations:

- You have the right to request restrictions on certain uses and disclosures of your PHI by Healing Hearts.
- You have the right to request that we communicate with you in a certain way. We make every effort to honor your reasonable requests for confidential communication.
- You have the right to read, review and receive copies of your health information.
- You have the right to request and obtain an accounting of disclosures Healing Hearts has made of your PHI.
- You have the right to request an amendment to your PHI. (Healing Hearts reserves the right to deny requests to amend PHI. For example, if the information is accurate, or if the information was not created or is not maintained by Healing Hearts.)
- You have the right to request a copy of the Privacy Notice.
- You have the right to file a complaint if you believe that Healing Hearts has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules.

By my signature below, I acknowledge that I have received a copy of the **Healing Hearts Notice Privacy Practices**.

_____ _____/_____/_____

Patient Name (Print) Date of Birth

_____ _____/_____/_____

Patient Signature Date of Acknowledgment

Adnan Afzal, M.D., F.A.C.C.
Hussein Yamani, M.D., F.A.C.C.
Arindam Banerjee, M.D., F.A.C.C.
Preeti Desai, M.D., F.A.C.C.

HEALING HEARTS

Please Send My Records To:

Healing Hearts
Attn: Medical Records
100 Medical Center Blvd., Suite 200
Conroe, TX 77304

RELEASE OF RECORDS AUTHORIZATION

TO HAVE RECORDS AVAILABLE AT THE TIME OF YOUR VISIT, PLEASE COMPLETE AUTHORIZATION AND FORWARD, AS SOON AS POSSIBLE, TO THE PHYSICIAN OR FACILITY YOU WISH TO RELEASE YOUR RECORDS

Patient Name:	**Date of Birth:**
Address:	**Social Security #:**
City: State: Zip:	**Telephone #:**

I hereby authorize the release of my medical records from:

Physician:		**Telephone #:**
Address:		**Fax #:**
City:	**State:**	**Zip:**

I ❒ **do** ❒ **do not** (check applicable box) authorize this information to be faxed.	Fax #: **936-539-9685**
Name of person to receive information:	

REASON FOR RELEASE OF INFORMATION (check the appropriate box)

❒ **Medical Care** ❒ **Transfer of Medical Care** ❒ **Moving Out of Area** ❒ **Insurance**
❒ **Transfer of Care** ❒ **Specialist Consultation** ❒ **Personal File** ❒ _____

I understand that if I request copies of records for myself, or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

INFORMATION TO BE DISCLOSED (check the appropriate box)

❒ **Complete health records for the past 2 years** ❒ **History & Physical Exam** ❒ **Consultations**
❒ **Progress Notes** ❒ **Laboratory Tests** ❒ **Billing Records**
❒ **Other** _____

I understand this material may contain information relating to: Acquired Immunodeficiency Syndrome (AIDS) infection with HIV (Human Immunodeficiency Virus), Mental Health, Alcohol and/or Drug Abuse, Family History, Social History

REVOCATION: I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION FOR THE PURPOSES STATED ABOVE.

UNLESS OTHERWISE INDICATED, THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. THE PHYSICIAN AND EMPLOYEES ARE RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.

I understand there may be a fee for preparing and furnishing this information.

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**

RELEASE OF HEALTH INFORMATION

PRIMARY CARE PHYSICIAN (PCP): _____

Address of PCP: _____

☐ Healing Hearts **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone, except as permitted by HIPAA and other applicable laws.

☐ Healing Hearts **MAY** discuss my healthcare and **MAY** discuss and/or make financial arrangements with only the following individual immediate family members listed below:

Name _____ Relationship _____ Phone (____)_____

Name _____ Relationship _____ Phone (____)_____

Name _____ Relationship _____ Phone (____)_____

I understand that if I would like to authorize Healing Hearts to disclose my healthcare and/or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards.

_____ _____ _____/_____/_____

Patient Name (Please Print) Patient Signature Date

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection.

☐ No Expiration
☐ Date of Expiration _____/_____/_____
☐ Event: (Describe event upon which this Authorization will expire) _____

PATIENT CONTACT PREFERENCES

I prefer to be contacted in the following manner:
- ❑ Phone #: (_____) _____ - _____
- ❑ OK to leave message with detailed information
- ❑ OK to leave message with contact number only
- ❑ DO NOT LEAVE MESSAGE

Patient Portal Email: (PLEASE PRINT) _____ .

Appointment reminders:
- ❑ Text [# if different than above (_____) _____ -_____]
- ❑ Phone
- ❑ Email

New Patient Medical Questionnaire

Patient Name: _____ DOB: ____/____/____ DATE:____/____/____

What physician requested this consult?_____

CHIEF COMPLAINT

What problems are you here for today? _____

_____

_____

CARDIAC PROBLEM LIST

Please check any of the following disorders that you HAVE or HAVE HAD, and indicate the year it was first identified.

CARDIAC:

☐ **Yes** ☐ **No** Cardiomegaly (Enlarged Heart) _____

☐ **Yes** ☐ **No** Heart Disease born with(congenital)_____

☐ **Yes** ☐ **No** Rheumatic Fever _____

☐ **Yes** ☐ **No** Murmur_____

☐ **Yes** ☐ **No** Abnormal Heart Valve _____

☐ **Yes** ☐ **No** Endocarditis (infected heart valve)_____

☐ **Yes** ☐ **No** Abnormal ECG_____

☐ **Yes** ☐ **No** Angina (heart pain)_____

☐ **Yes** ☐ **No** Heart Attack _____

☐ **Yes** ☐ **No** Coronary Artery Disease _____

☐ **Yes** ☐ **No** Heart Failure / Cardiomyopathy _____

☐ **Yes** ☐ **No** Arrhythmia / Abnormal Rhythm_____

☐ **Yes** ☐ **No** Previous Cardiac Arrest _____

☐ **Yes** ☐ **No** Defibrillated / Shocked _____

☐ **Yes** ☐ **No** Pericardial(sac surrounding heart) Disease_____

☐ **Yes** ☐ **No** Marfan's Syndrome_____

☐ **Yes** ☐ **No** Hospitalized for cardiac reasons_____

☐ **Yes** ☐ **No** Other type of heart disease_____

VASCULAR:

☐ **Yes** ☐ **No** Carotid Artery Disease _____

☐ **Yes** ☐ **No** Renal(kidney) Artery Disease _____

☐ **Yes** ☐ **No** Peripheral(leg or arm) Artery Disease _____

☐ **Yes** ☐ **No** Pulmonary embolism (clots in lung) _____

☐ **Yes** ☐ **No** Varicose Veins _____

☐ **Yes** ☐ **No** Stroke or TIA (mini-stroke)_____

☐ **Yes** ☐ **No** Any history of aneurysm _____

☐ **Yes** ☐ **No** DVT (clots in leg) _____

☐ **Yes** ☐ **No** Other type of vascular Disease _____

CORONARY RISK FACTORS

☐ **Yes** ☐ **No** Hypertension (high blood pressure) _____

☐ **Yes** ☐ **No** Abnormal Cholesterol / Triglycerides_____

☐ **Yes** ☐ **No** History coronary disease in immediate family?

☐ **Yes** ☐ **No** Diabetes Mellitus _____

☐ **Yes** ☐ **No** Currently Smoking?_____

☐ **Yes** ☐ **No** Peripheral artery disease? (legs, carotids)_____

_____

_____

New Patient Medical Questionnaire

Patient Name: _____ DOB: ____/____/____ DATE:____/____/____

List all Medical Problems/Conditions, Past and Present:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

List all Surgeries {Include year):

1. _____
2. _____
3. _____
4. _____
5. _____

List Other Hospitalizations (include year):

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications and Dosages:
{Include herbs, vitamins, and over the counter)

1. _____
2. _____
3. _____
4. _____
5. _____

List Medication Allergies:
(Include reaction type)

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had a problem with alcohol or drug abuse? ☐ **Yes** ☐ **No**

If yes, which one? _____

Check all that apply:

Smoke: ☐ No If yes, Amount/day_____ Number of years: _____

Alcohol: ☐ No If yes, Amount/Day _____ Illicit Drugs: ( ) No If yes, Type _____

Caffeine: ☐ No If yes, Amount/Day _____

Exercise: ☐ Never ☐ 1---2 Days/Week ☐ 3---7 Days/Week

New Patient Medical Questionnaire

Patient Name: _____ DOB: ____/____/____ DATE:____/____/____

Family History

Mother: If living, Age: _____

Health Problems: _____

If deceased, cause of death: _____

Father: If Living, Age: _____

Health Problems: _____

If deceased, cause of death: _____

Have you had any relatives with the following: (If yes, list relation)

Diabetes: _____

Heart Disease: _____

High Blood Pressure: _____

Stroke: _____

Osteoporosis: _____

Cancer, please list the type: _____

Any other reason why you need to see a cardiologist?

_____

_____

_____

_____

_____

New Patient Medical Questionnaire

Patient Name: _____ DOB: ____/____/____ DATE: ____/____/_____

CARDIAC:

Chest pain	☐ **Yes**	☐ **No**
Chest pressure	☐ **Yes**	☐ **No**
Shortness of breath	☐ **Yes**	☐ **No**
Difficulty breathing while laying flat	☐ **Yes**	☐ **No**
Awakening with breathing difficulty	☐ **Yes**	☐ **No**
Swelling in feet/ankles	☐ **Yes**	☐ **No**
Palpitations	☐ **Yes**	☐ **No**
Nearly passing out spells	☐ **Yes**	☐ **No**
Passing out spells	☐ **Yes**	☐ **No**

CARDIAC PROCEDURES/DIAGNOSTIC TESTING

Please check that you have had or have not had any procedures / diagnostic tests. Write the year and the location of the test in the blank

			Year	**Location**
☐ Yes	☐ No	Echo (Cardiac Ultrasound)	_____	_____
☐ Yes	☐ No	Stress Test	_____	_____
☐ Yes	☐ No	Holter/Event Monitor	_____	_____
☐ Yes	☐ No	Carotid Artery Ultrasound	_____	_____
☐ Yes	☐ No	Heart Catheterization	_____	_____
☐ Yes	☐ No	Heart Angioplasty/Stent Placement	_____	_____
☐ Yes	☐ No	Peripheral Artery Angiogram (Non Heart)	_____	_____
☐ Yes	☐ No	Peripheral Artery Angioplasty (Non Heart)	_____	_____
☐ Yes	☐ No	Electrophysiology Study	_____	_____
☐ Yes	☐ No	Heart Rhythm Ablation	_____	_____
☐ Yes	☐ No	Pacemaker/ICD(defibrillator)	_____	_____
☐ Yes	☐ No	Cardiac Surgery	_____	_____

Thank you for taking the time to complete this questionnaire.

Patient Signature _____