M. Akram Khan MD, FACC, FSCAI
4201 Medical Center Dr., Suite 380, McKinney, TX 75069 Tel: 972-529-6939 Fax: 972-529-6935
Services@CardiacCenterOfTexas.com • www.CardiacCenterOfTexas.com

INSURANCE AND BILLING INFORMATION

Name:________________ Date of Birth:________ Age:______ SSN:__________

Address:________________ City:____________ State:__________ Zip:________

Sex: [ ] Male [ ] Female Marital Status: [ ] Divorced [ ] Married [ ] Single [ ] Widowed

Home Phone:____________ Cell/Pager:____________ Email Address:________________

Employer:________________________ Work Phone:____________

Employer Address:________________ City:____________ State:______ Zip:________

Primary Care Physician:________________________ Office Phone:____________

Referring Physician:________________________ Office Phone:____________

Name of Closest Relative Not Living With You:________________ Phone: ____________

Relative's Address:________________ City:____________ State:______ Zip:________

How did you hear about us: [ ] Doctor [ ] Relative/Friend [ ] Internet [ ] Other:________________

SPOUSE'S INFORMATION

Name:________________ Date of Birth:____________ SSN:____________

Address:________________ City:____________ State:__________ Zip:________

Home Phone:____________ Cell/Pager:____________ Email Address:________________

Employer:________________________ Work Phone:____________

Employer Address:________________ City:____________ State:______ Zip:________

INSURANCE INFORMATION

Primary Insurance Company:________________________ Relationship to Insured:[ ] Self [ ] Child

Name of Person Insured:________________________ [ ] Spouse [ ] Other

Policy Holder's Date of Birth:________________ Sex: [ ] Male [ ] Female SSN:____________

ID:________________ Group:________________ Phone:____________

Address to Mail Claims:________________ City:____________ State:______ Zip:________

Referral Obtained from PCP: [ ] Yes [ ] No Co-Pay: $____________ Deductible: $____________

Secondary Insurance Company:________________________ Relationship to Insured:[ ] Self [ ] Child

Name of Person Insured:________________________ [ ] Spouse [ ] Other

Policy Holder's Date of Birth:________________ Sex: [ ] Male [ ] Female SSN:____________

ID:________________ Group:________________ Phone:____________

Address to Mail Claims:________________ City:____________ State:______ Zip:________

Referral Obtained from PCP: [ ] Yes [ ] No Co-Pay: $____________ Deductible: $____________

I hereby assign my insurance benefits to be paid to Cardiac Center of Texas, P.A. I understand that I am financially responsible for this bill, regardless of insurance coverage. I also authorize the release of any information required in the processing of insurance claims. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).

Patient Signature:________________________ Date:____________

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PATIENT HISTORY

Name:________________________ Date of Birth:__________ Age:________ Sex: [ ] Male [ ] Female

Reason for Visit:________________________ Height:______ Weight:______ Occupation:____________

Marital Status:[ ] Divorced [ ] Married [ ] Single [ ] Widowed Number of Children:____ Primary Care Physician:__________

Allergies:________________________ Pharmacy Name:______________ Phone:__________

Personal History Of:	Yes	When
Asthma	[ ]	
Arrhythmia/Palpitations	[ ]	
Blockages:	[ ]	
Carotid (Neck) Arteries	[ ]	
Coronary Arteries	[ ]	
Kidneys	[ ]	
Leg Vessels	[ ]	
Other:	[ ]	
Chest Pain/Angina	[ ]	
Congestive Heart Failure (CHF)	[ ]	
Coronary Obstructive Pulmonary Disease (COPD)	[ ]	
Diabetes	[ ]	
Dizziness/Fainting	[ ]	
Emphysema	[ ]	
Heart Attack	[ ]	
Heart Murmur	[ ]	
Heart Valve Problems	[ ]	
High Blood Pressure	[ ]	
High Cholesterol	[ ]	
Obesity	[ ]	
Palpitations	[ ]	
Shortness of Breath	[ ]	
Stroke/TIA	[ ]	
Other:	[ ]	
Family History Of:	**Yes**	**In Whom**
Diabetes	[ ]	
Heart Attack	[ ]	
High Blood Pressure	[ ]	
High Cholesterol	[ ]	
PVD/Aneurysm	[ ]	
Stroke	[ ]	
Sudden Cardiac Death	[ ]	
Other:	[ ]	
Do You:	**Yes**	**How Often**
Drink Alcohol	[ ]	
Exercise	[ ]	
Use Tobacco Products	[ ]	
Interested in Quitting?	[ ]	
Other:	[ ]	

Procedures:	Yes	When	Where
Angioplasty/Bypass	[ ]		
Cardiac CT	[ ]		
ECHO	[ ]		
EKG	[ ]		
Heart Catheterization	[ ]		
Holter Monitor	[ ]		
Nuclear Stress Test	[ ]		
Recent Hospitalization	[ ]		
Reason:	[ ]		
Other:	[ ]		
Surgeries:	**Yes**	**When**	**Where**
Aneurysm	[ ]		
Cardiac:	[ ]		
Angioplasty/Stents	[ ]		
Bypass	[ ]		
Defibrillator	[ ]		
Pacemaker	[ ]		
Valve	[ ]		
Carotid	[ ]		
Kidney:	[ ]		
Angioplasty/Stents	[ ]		
Bypass	[ ]		
Leg Vessels:	[ ]		
Angioplasty/Stents	[ ]		
Bypass	[ ]		
Other:	[ ]		

Current Medications	Dose	How Often	Reaction

(please continue on other side)

Are there any other issues we should be aware of?____________________________

____

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CONSENT TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Your protected health information will be used by Cardiac Center of Texas, P.A. or disclosed to others, for the purposes of treatment, obtaining payment, or supporting the day-to-day healthcare operations of this practice.

THE NOTICE OF PRIVACY PRACTICES
Cardiac Center or Texas, P.A. is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide to you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. Please review it carefully.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION
You may request a restriction on the use or disclosure of your protected health information. However, Cardiac Center of Texas, P.A. may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information.
It is a violation of the federal privacy standards of Cardiac Center of Texas, P.A. agrees to and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the "Notice of Privacy Policies and Practices" brochure, please consult with a practice representative.

YOU MAY REVOKE THIS CONSENT AT ANY TIME
You may revoke this consent at anytime; however, Cardiac Center of Texas, P.A. requires that you must revoke this consent in writing. If you revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES
Cardiac Center of Texas, P.A. reserves the right to change or modify the privacy practices outlined in the "Notice of Privacy Policies and Practices" brochure. Cardiac Center of Texas, P.A. will notify you of any changes of privacy practices by mail or in person.

EMAIL CONSENT
To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at www.cardiaccenteroftexas.com. Please remember, however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 1-3 business days. The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate. Communications relating to diagnosis and treatment will be filed in your medical record.

When sending email, please put the subject of your message in the subject line. Also, be sure to put your name, date of birth, and return telephone number in the body of the message.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to one particular employee, Cardiac Center of Texas, P.A. staff may have access to this email.

By signing below you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

I have reviewed this consent form, acknowledge receipt of the brochure entitled "Notice of Privacy Policies and Practices", and give my permission to Cardiac Center of Texas, P.A. to use and disclose my health information in accordance with this consent and the notice provided. I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond Cardiac Center of Texas, P.A. control. I understand and agree to the above email policy.

Cardiac Center of Texas, P.A. may:

Leave me voicemail messages	Yes	No	
Speak to family members that answer my phone	Yes	No	
Obtain my medication list from my insurance company	Yes	No	
Communicate with me via email	Yes	No	Email address:_______________

_______________________________ Signature of Patient or Personal Representative

_______________________________ Date

_______________________________ Printed Name of Patient or Personal Representative

_______________________________ Description of Personal Representative's Authority, If Applicable

PERMISSION TO DISCUSS MEDICAL INFORMATION

By signing this form, I authorize you to use and disclose the protected health information described below:

Patient Name:____ Date of Birth:____________________

The health information you may release subject to this authorization is as follows:

____

____

Do you authorize Cardiac Center of Texas, PA, to discuss your care and treatment with any party other than yourself? [ ] No [ ] Yes

Other:_______________________________________ Relationship:______________________________

Other:_______________________________________ Relationship:______________________________

Other:_______________________________________ Relationship:______________________________

The reasons or purposes for this release of information are as follows:

____

This authorization shall be in force and effective until the following event and/or date: ______________________________

I understand that I have the right to revoke this authorization, in writing, at any time, by sending or delivering a written notification to:

Cardiac Center of Texas, PA – Privacy Officer
4201 Medical Center Drive, Ste. #380
McKinney, Tx 75069
Phone: (972) 529-6939
Fax: (972) 529-6935

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Cardiac Center of Texas, PA, will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

______________________________ ______________________________
Signature of Patient or Personal Representative | Date

______________________________ ______________________________
Printed Name of Patient or Personal Representative | Description of Personal Representative's Authority, If Applicable

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

Name:____ Date of Birth:__________ Age:______ SSN:____________________

Address:__________________________________ City:________________________ State:_______________ Zip:__________

Previous Names:____

I hereby consent and authorize to release medical record information concerning the above-mentioned patient:

FROM:

____
Name (facility to release the information)

____
Address

____
City, State, Zip

____
Phone Fax

MAIL TO:
Cardiac Center of Texas, P.A. – Medical Records
4201 Medical Center Drive, Ste. #380
McKinney, Tx 75069

FAX TO:
(972) 529-6935
Attention: Medical Records

Purpose of the Release: [ ] Appointment/Continuation of Care [ ] Personal Use

Information to be released:
[ ] Complete medical history records concerning my illness and/or treatment.
-Or-

[ ] Consultations [ ] CT(s) [ ] ECHO(s) [ ] EKG(s) [ ] Event Monitor
[ ] Heart Cath(s) [ ] Holter Monitor [ ] Laboratory [ ] Medication(s) [ ] Nuclear Medicine
[ ] Office Notes [ ] Treadmill [ ] Other:____

Dates of Service:_________ to _________. (The last 2 years of treatment should be released if no dates of service are specified.)

We will not disclose your medical information for any purpose except for treatment, payment, and healthcare operations. This consent will remain in effect unless otherwise revoked. I have given my consent freely, voluntarily, and without coercion. I have the right to inspect and copy the information being requested for use or disclosure. I can refuse to sign the authorization without retaliation. I understand that information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA's privacy rule protections. I understand that any releases, which are not made prior to my revocation incompliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

______________________________________ ______________________________
Signature of Patient or Personal Representative Date

______________________________________ ______________________________
Printed Name of Patient or Personal Representative Description of Personal Representative's Authority, If Applicable

Records Prepared and Transmitted By:

______________________________________ ______________________________
Signature of Cardiac Center of Texas, P.A. Representative *Date*

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MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your health care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 48 hours.

Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 48 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 48 hours in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients.

Missed appointments for **Office Visits** will incur a **$50.00** charge.

Missed appointments for **Nuclear Stress Tests** will incur a **$250.00 wasted dosage fee.** Medications are ordered for these exams that are specific to your height and weight and cannot be saved or used on another patient.

For **VEIN PROCEDURES** such as **Endovenous RFA, Sclerotherapy or Phlebectomy**, failure to provide such notice will result in a charge of **$150.00**.

Patient Signature ______________________ Date ______________________

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INTRODUCING A NEW WAY TO STAY IN TOUCH WITH YOUR PHYSICIAN AND NURSE

YOU CAN:

- Request an appointment
- Communicate with your physician and nurses
- Access your personal information and make necessary changes
- Renew your prescriptions

GO TO HTTPS://PATIENT.CARDIACCENTEROFTEXAS.COM/PORTAL/ AND CREATE AN ACCOUNT ONLINE.