Comprehensive Heart Care, PA
Patient Registration Form

Physician's (please check physician you are seeing today)

□ Luis Campos, MD, FACC □ Salah El Hafi, M.D. □ Shahin Tavackoli, MD, FACC
□ Marco Campos, MD, FACC □ W. Ross Brown, MD, FACC

PATIENT INFORMATION (Please Print)

Patient's Name (Last)_____

(First) _____ (MI) _____Previous Name _____

Address_____ City_____ ST _____ ZIP_____

Please provide all contact numbers:
Home# _____Cell#_____ Work#_____

Primary Care Provider (PCP)
_____

Referring Provider_____

Date of Birth __ __ __ / __ __ / __ __ **Sex** □ Female □ Male □ Transgender
MONTH DAY YEAR

Race □ American Indian/Alaska Native □ Asian □ Native Hawaiian/Pacific Island □ Black African American □ White Caucasian □ Hispanic □ Other □ Declined

Ethnicity □ Hispanic/Latino □ Not Hispanic or Latino □ Declined

Language □ English, □Spanish □ Indian □ Japanese □ Chinese □ Korean
□ French □ German □ Russian □ Other

Marital Status □Married □Single □Divorced □ Widow □Legal Separated □ Partner

Patient Social Security Number: _____ -_____ - _____

*****Patient E-Mail Address**: _____
THIS IS FOR PATIENT PORTAL SIGN UP ***DO NOT LEAVE BLANK***

Employer Name_____
Employment status □ Full-Time □ Part time □ Not employed □ Retired □ Self Employed

Emergency Contact
Last Name_____ First Name _____ Relation to Patient:_____

Phone# _____Cell #_____

Do you have a living will? □ Yes □ No

Pharmacy Name: _____Phone Number: _____
RESPONSIBLE PARTY INFORMATION (Information used for (Patient Balance Statements)

Responsible Party: □ Self □ Another Patient □ Guarantor Sex: F M

Responsible Party Name (Last) _____ (First)_____ (MI) _____

Guarantor Date of Birth _____MM_____ /DD_____YYYYY_____

Guarantor Social Security Number_____-_____-_____

PRIMARY INSURANCE INFORMATION
(Provide your insurance card to the front desk at check in)
****ONLY FILL THIS OUT IF YOU ARE NOT THE PRIMARY POLICY HOLDER****
Name of Insured_____

Relationship to Insured_____

Date of Birth _____MM_____DD_____YYYYY

SECONDARY INSURANCE INFORMATION
Name of Insured_____

Relationship to Insured_____

Date of Birth _____MM_____DD_____YYYYY

How would you like to be contacted by our practice?

Please check all options that apply:

□ TEXT MESSAGING □ EMAIL □ MAIL TO ADDRESS PROVIDED

□ TELEPHONE: Preferred time to call?: □ Morning □ Afternoon □ Evening

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.
Patient (or Responsible Party)

Signature_____ Date_____

Print Name _____

COMPREHENSIVE HEART CARE, PA

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Comprehensive Heart Care, PA to use and disclose protected health information (PHI) about myself regarding treatment payment and healthcare operations. (TPO) [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of Comprehensive Heart Care, PA reserves the right to revise its Notice of Privacy Practices anytime.

A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, I grant Comprehensive Heart Care, PA to view my prescription history from external sources.

With this consent, the office of Comprehensive Heart Care, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of Comprehensive Heart Care, PA may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked • Personal and Confidential (We do not mark ours personal and confidential)

With this consent, the office of Comprehensive Heart Care, PA may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of Comprehensive Heart Care, PA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Please do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. No one can diagnose your condition from email or other written communications, and communication via our website cannot replace the relationship you have with a physician or another healthcare practitioner.

By signing this form, I am consenting to the office of Comprehensive Heart Care, PA use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of Comprehensive Heart Care, PA may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient Name Print Guardian Name

Authorization Form

For Release of Protected Health Information

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

Patient Name: _____

Release my protected health information to the following person(s)/entity:

Name: _____ Phone:_____

Name: _____ Phone:_____

Name: _____ Phone:_____

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 a written notification to the following person at the practice:

Diana B, Beckham

713-465-3535 fax: 713-465-9735

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.

The practice 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

_____PRINT Name of Patient or ***Personal Representative***

_____Description of ***Personal Representative's Authority***

COMPREHENSIVE HEART CARE, PA FINANCIAL PAYMENT POLICY

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. We have therefore taken the time to answer some of the most commonly asked questions.

Cash paying and insurance balances, how can I pay?

- *We accept payment by cash, check, VISA, MasterCard, Discover, and American Express.*
- *If services are paid in full the day of service a 20% courtesy discount will be applied.*
- *All patient responsible balances are due at the time of service.*

We feel strongly that it is the patient's responsibility to be aware of the requirements and limitations of their own benefits and insurance plans. Please let our office know if your insurance has requirements regarding participating outpatient facility and laboratory. For services rendered in our office and outpatient facilities please note that you may also receive bills from other entities for services rendered in conjunction with your care (i.e, laboratory services).

Co-pays are required at the time of the visit.

Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems their services as non-covered will be billed directly for these charges.

In exchange for filing your insurance, ***you agree to provide current insurance information and picture I.D at every office visit.*** We understand that filling out forms is at times tedious; we do our best to simplify this process.

Check Policy

We are happy to accept your personal check for payment. However, if funds are not available in your account and your check is returned to us as a NSF (or for any other reason), ***you will be assessed a $35 service fee plus the amount of the original check***. You may be required to make future payments using cash, credit card or money order.

No Show Policy/ Late Cancellation Policy

Any time that you miss a Nuclear appointment in our office or cancel a Nuclear appointment without giving us 24 hours' notice, you will be assessed a $250 for no-show/late cancellation fee. This fee will be your responsibility and must be paid in full prior to your next visit.

Application/ Form Completion Fees

A prepayment fee up to $35 must be paid in full for forms and applications completion such as a disability application that does not require you to come to the office.

Medical Record Fees

Charges for Medical Records copies will be determined in accordance with the current State of Texas Office of Planning and Budget published rates.

Minimum costs are approximately **$25.00** as a base fee in addition to a **per page cost of $1.00.**

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and co-insurance amounts, are my responsibility.

_____

Signature

_____ _____

Print Name **Date**