Pecan Plantation
2800 Village Road, Suite 108
Granbury, Texas 76049
PHONE: (254) 897-1434 **FAX:** (254) 897-1409

Thank you for choosing HeartPlace for your cardiology needs.

Your appointment is scheduled with _____ on _____ @ _____

Please arrive 15 minutes early and wear appropriate clothing for exercising on a treadmill.

Enclosed you will find your new patient paperwork. All paperwork **MUST** be in our office 3 days **BEFORE** the visit – *NO EXCEPTIONS. IF WE DO NOT HAVE YOUR PAPERWORK YOU WILL HAVE TO RESCHEDULE YOUR APPOINTMENT!!!*

It is your responsibility to make sure 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.

- Be sure to bring a good list of all medications (or bring all of your medication bottles with you) along with any other forms of supplements you may take on a daily basis.
- Bring your insurance card and Driver's License. If these are not presented you will be required to reschedule your appointment.
- Be sure to fill out and sign each document in this packet:
  1. **PATIENT DEMOGRAPHICS**
  2. **PATIENT PRIVACY NOTICE / RELEASE OF INFORMATION AUTHORIZATION**
  3. **CONTACT PREFERENCES**
  4. **SURESCRIPTS AUTHORIZATION**
  5. **REQUEST FOR RELEASE OF MEDICAL RECORDS TO HEARTPLACE**
  6. **ALTERNATE TELEPHONE NUMBER IN CASE OF ANY EMERGENCY**
  7. **HEARTPLACE HEB FINANCIAL AGREEMENT**
  8. **DISCLOSURE OF PHYSICIAN OWNERSHIP (NOTICE TO PATIENTS)**
  9. **MEDICAL HISTORY QUESTIONNAIRE**

For Office Use Only
Verified Date: _____
By: _____
System Account#: _____

How did you hear about HeartPlace?
❑ Physician Referral ❑ Advertisement
❑ Friend ❑ Other: _____ Date: _____

Patient Information

Name: _____ Doctor: _____
last first middle

Social Security #: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph.: (_____) _____ Business Ph.: (_____) _____ Cell Ph.: (_____) _____

❑ Married ❑ Single ❑ Widow ❑ Divorced Age: _____ Date of Birth: _____ ❑ Male ❑ Female

Employer Name: _____ Employer Address: _____

❑ Full-Time ❑ Part-Time ❑ Retired ❑ Self-Employed ❑ Student Full-Time ❑ Student Part-Time

Referring Physician: _____ Referring Physician Ph.: (____) _____

Primary Care Physician: _____ Primary Care Physician Ph.: (____) _____

Insured Name (If no insurance, responsible party)

Name: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph.: (_____) _____ Business Ph.: (_____) _____ Cell Ph.: (_____) _____

Employer Name: _____ Employer Address: _____

Notify In Case of Emergency

1. Name: _____ Relationship: _____ Ph.#: _____ Wk.#: _____

2. Name: _____ Relationship: _____ Ph.#: _____ Wk.#: _____

Insurance Information – Copies of Insurance Cards and Drivers License are Required

Insurance 1: _____

Address: _____ Ph.#: (____) _____

SS#: _____ Policy #: _____ Group #: _____

Insurance 2: _____

Address: _____ Ph.#: (____) _____

SS#: _____ Policy #: _____ Group #: _____

Authorizations

For and in consideration of the services rendered by HeartPlace, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgements obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign HeartPlace all rights, title and interest in any payment due me for services described herein as provided in the above-mentioned policies of insurance/settlements or judgements. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Patient Signature: _____ Date: _____

Patient Name (Please Print): _____

Witness Signature: _____ Date: _____

HEARTPLACE 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 HeartPlace 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?

HeartPlace 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 HeartPlace 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. HeartPlace 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 HeartPlace office staff.

When might HeartPlace use or disclose my PHI without my authorization?

HeartPlace 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, HeartPlace 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 HeartPlace.
- 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 HeartPlace has made of your PHI.
- You have the right to request an amendment to your PHI. *(HeartPlace 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 HeartPlace.)*
- You have the right to request a copy of the Privacy Notice.
- You have the right to file a complaint if you believe that HeartPlace has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules.

HEARTPLACE PRIVACY OFFICER

HeartPlace has procedures in place for receiving and resolving HIPAA-related complaints, and, handling other HIPAA and PHI requests and concerns. Such issues are handled by the **HeartPlace Privacy Officer**. You may:

- Request additional restrictions for release of your PHI
- Change restrictions/change contact information
- Request an amendment to your health record
- Request copies of the Notice
- Resolve your complaints *(complaints must be directed in writing to the Privacy Officer).*

Contact the HeartPlace Privacy Officer:
By Mail: HeartPlace, Attn: Privacy Officer, 16980 Dallas Parkway, Suite 200 Dallas, TX 75248
By Phone: (972) 391- 1900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____/_____/_____
Patient Name (Print) Date of Birth

_____ _____/_____/_____
Patient Signature Date of Acknowledgement

RELEASE OF HEALTH INFORMATION

PRIMARY CARE PHYSICIAN (PCP): _____

Address of PCP: _____

❑ HeartPlace **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.

❑ HeartPlace **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 HeartPlace 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

All normal test results will be sent via our **Patient Portal** to **Email**: (PLEASE PRINT)

_____ @ _____ . _____

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

AUTHORIZATION FOR ACCESS AND USE OF SURESCRIPTS PRESCRIPTION HISTORY

HeartPlace, with your authorization, has the ability to import the last 16 months of your prescription history directly from the Surescripts E-prescribing database. Surescripts is used by most pharmacies and insurance companies to process prescriptions. If you paid cash or did not pickup a prescription, it will not be in the Surescripts database.

The import of Surescripts prescription history is not required for treatment. HeartPlace understands there may be situations, prescriptions, and medical history you do not want to share with your physician. Notifying your physician of all your medical history and currently prescribed medications is critical for proper care.

I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization") by Surescripts and the access and use of that information by HeartPlace, P.A. ("HeartPlace").

Patient's Name: _____ **Date of Birth: _____**

Name of organization(s) authorized to access, use or receive the Protected Health Information: **Surescripts and HeartPlace.** Specific description of Protected Health Information to be accessed, used or disclosed: Prescription drug information, including patient medication history data, maintained in the Surescripts electronic prescription data system.

Event on which this Authorization will expire: **One year**

I understand that I may refuse to sign this Authorization, and that my health care treatment will not be conditioned upon signing this form. I also understand that my Protected Health Information is subject to redisclosure to the authorized recipient of the Protected Health Information pursuant to this Authorization. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace or Surescripts took before it received the revocation of this Authorization. I understand that I may see and copy the Protected Health Information described on this Authorization, if I request to do so in writing. I understand that I will receive a copy of this Authorization after I sign it.

Will HeartPlace or any of its providers receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes___ No__X_**

_____ _____
Signature of individual or individual's representative Date

_____ _____
Printed name of individual's representative Relationship to patient

_____ _____
Witness Date

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

HeartPlace®
The Future Of Cardiology Is Here

Pecan Plantation

Cardiologists
Andrew Miller, MD, FACC

Date: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Physician or Hospital

_____
Address

_____
City State Zip Code

I hereby request that my medical records be released to:

HeartPlace Pecan Plantation
2800 Village Road, Suite 108
Granbury, Texas 76048
PHONE: (254) 897-1434
FAX: (254) 897-1409

Patient Name (PRINT): _____ DOB: _____

Patient Signature: _____ Date: _____

Social Security #: _____ Date of Treatment: _____

HeartPlace®
The Future Of Cardiology Is Here

Date: _____

ALTERNATE TELEPHONE NUMBER
IN CASE OF ANY EMERGENCY

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Patient Name (PRINT): _____ DOB: _____

Patient Signature: _____

HeartPlace Pecan Plantation Financial Agreement

Thank you for choosing HeartPlace for your cardiovascular needs. The patient financial agreement was developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of our patient financial agreement is important to our professional relationship. Please read the agreement below and sign where indicated.

- **Copayments, Deductibles, & Co-Insurance:** It is also your responsibility to be aware of your co-pays, deductible, and co-insurance amounts. We expect all co-payments, deductibles and co-insurance to be paid at the time of services unless other arrangements have been made in advance. In addition, each time you come to our facility, you will be asked to pay balances on past due accounts and on current balance owed.

- **Referrals:** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment.

- **Authorizations:** Obtaining prior authorizations for services is not a guarantee of payment. A prior authorization means the information given at the time meets the medical necessity for the service, but not a guarantee of payment.

- **Self Pay Patients:** Payment is expected at the time of service unless other financial agreement has been made prior to your visit.

- **Medicare Patients:** We will submit all claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one. If you do not have a secondary insurance the 20% co-insurance I payable at the time of service.

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company.

Patient Name: _____ DOB: _____
(Please Print)

Signature: _____ Date: _____
(Patient or Responsible Party)

Responsible Party Name: _____
(Please Print Name of Responsible Party if different from Patient)

Established Patient Questionnaire

Date: _____

Patient Name: _____ **DOB:** _____ **AGE:** _____

Family physician: _____ **Last seen?:** _____

Other physicians that care for you: _____

Reason for today's visit: routine follow-up hospital follow-up urgent work-in

Chief Complaint (What problems are you here for today?): _____

Last HeartPlace Physician Encounter Date: _____ **Setting:** office hospital ER

Pharmacy: _____ **City/Intersection/Phone:** _____

Since your last visit with us have you had any…?			**Comments**
New illnesses?	❑ Yes	❑ No	_____
Hospitalizations or ER visits?	❑ Yes	❑ No	_____
Surgical procedures?	❑ Yes	❑ No	_____
Drug allergies/reactions?	❑ Yes	❑ No	_____
Started or continued to smoke?	❑ Yes	❑ No	Type, how much, how often? _____
Alcohol consumption?	❑ Yes	❑ No	Type, how much, how often? _____
Caffeine consumption?	❑ Yes	❑ No	Type, how much, how often? _____
Exercise?	❑ Yes	❑ No	Type, how often, how long? _____
Home exercise equipment?	❑ Yes	❑ No	Type? _____
Special diet?	❑ Yes	❑ No	Type? How compliant? _____
Home blood pressure measurement?	❑ Yes	❑ No	Average reading? _____
Blood work done?	❑ Yes	❑ No	When? Where? _____
Cholesterol checked?	❑ Yes	❑ No	When? Where? _____
Medication refills needed?	❑ Yes	❑ No	_____

Since your last visit with us have you experienced any…?

Chest pain or pressure?	❑ Yes	❑ No	Nearly passing out spells?	❑ Yes	❑ No
Shortness of breath?	❑ Yes	❑ No	Passing out spells?	❑ Yes	❑ No
Shortness of breath on exertion?	❑ Yes	❑ No	Recurrent Dizziness?	❑ Yes	❑ No
Difficulty breathing while laying flat?	❑ Yes	❑ No	Weight gain?	❑ Yes	❑ No
Awakening with breathing difficulty?	❑ Yes	❑ No	Weight loss?	❑ Yes	❑ No
Swelling in feet/ankles?	❑ Yes	❑ No	Increased stress?	❑ Yes	❑ No
Palpitations? (heart racing, skipping)	❑ Yes	❑ No			

_____

_____

_____

_____

Reviewed By: _____