SOUTHLAKE
1545 E. Southlake Blvd, Suite 250
Southlake, Texas 76092
PHONE: (682) 223-9112
FAX: (682) 223-9111

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

Southlake

Cardiologists
Andrew Miller, MD, FACC
Ali Moustapha, MD, FACC
Michael Mitchell, MD, FACC
Iyad Rashdan, MD, FACC
Alisa Thamwiwat, MD

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
1545 E. Southlake Blvd, Suite 250
Southlake, Texas 76092
PHONE: (682) 223-9112
FAX: (682) 223-9111

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 Southlake 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)

HeartPlace®
The Future Of Cardiology Is Here
A Professional Association managed by Cardiovascular Provider Resources

TREADMILL

Stress Test Instructions

1. Do not eat a heavy meal within two (2) hours of the test.
2. Wear two-piece, loose fitting clothing that is comfortable to exercise in.
3. Wear comfortable, rubber soled shoes.
4. Do not use bath oils, lotion or powder on the morning of the test.

   -You may use deodorant as usual.
5. Take all regularly prescribed medications unless otherwise directed by your physician.

*** Please note you may not have a stress test scheduled, your physician will consult with you prior to any testing being done by our office. We just want you to come prepared (and comfortable). Thank You!**

Texas Health Heart & Vascular Hospital™ ARLINGTON

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Dr. Iyad Rashdan, Dr. Ali Moustapha, and Dr. Andrew Miller are all partial owners of Texas Health Heart & Vascular Hospital Arlington.

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Texas Health Heart & Vascular Hospital Arlington.

3. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Texas Health Heart & Vascular Hospital Arlington.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Texas Health Heart & Vascular Hospital Arlington.

By signing this Disclosure of Physician Ownership, you acknowledge that you have had sufficient time to read and consider the information presented on this form, and you understand the foregoing notice and hereby understand that your physician has an ownership interest in Texas Health Heart & Vascular Hospital Arlington.

Patient Name: _____ DOB: _____
(Please Print)

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

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

NEW PATIENT VISIT

SOUTHLAKE

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ Other Physicians: _____

Patient	WHY ARE YOU HERE TO SEE A CARDIOLOGIST?	Clinician

History of Present Illness: (HPI) New Problem Existing Problem (CLINICIAN ONLY) Include the following elements: Location, Quality, Severity, Duration, Timing, Context, Modifying factors, and associated signs and symptoms. Brief = 1-3 Elements Extended = 4+ elements or status of 3+ chronic/inactive condition

Patient	Clinician

Social History:	
Where were you born? (City, State)	
Marital Status: (circle one) Single Married Divorced Widowed OTHER:	
Do you have any children? Yes No How many?	
Are you retired? Yes No Occupation:	
Do you smoke? Yes No, but used to Never	
When did you quit?	
How many packs do (or did) you smoke and for how many years? (example- 1 pack/day for 20 years)	
Do you drink alcohol? Yes No, but used to Never	
If you used to drink, when did you quit?	
How much do you drink in an average week? (circle one) 0-1 drinks/week 1-5 6-10 10+	
Have you ever been treated for drug dependency? Yes No Type(s):	
Are you following any special diet? Yes No If yes, specify:	
Do you drink caffeine? Yes No Type: Coffee Tea Cola OTHER:	
Do you exercise daily? Yes No Type(s):	

NEW PATIENT VISIT

Patient Name: _____ DOB: _____ Date: _____

Patient	Clinician

Past Medical History:		
Are you allergic to any medications? If yes, please list:	Yes	No
Are you allergic to iodine, shrimp, or shellfish?	Yes	No
Have you ever received X-Ray contrast in your veins? (e.g. Myleogram, Kidney series, CAT scan, etc.) If yes, did you have a problem with this?	Yes Yes	No No
Have you ever had a blood transfusion? If yes, when?	Yes	No
Have you ever had any operations or surgeries? If yes, please list what type and approximate date:	Yes	No
Women: Are you post-menopausal? If yes, are you taking hormonal replacement (estrogen)?	Yes Yes	No No

Family History:		
Father's Age:		or age at death:
Mother's Age:		or age at death:
Siblings: (brothers & sisters)		
1.	Age:	or age at death:
2.	Age:	or age at death:
3.	Age:	or age at death:
4.	Age:	or age at death:
5.	Age:	or age at death:
Medical Problems: (Check if yes)	Father:	Mother: Siblings:
Heart Attack		
Stroke		
Diabetes		
High Blood Pressure		
Angina		
Other Family members with heart problems: (example: paternal uncle, 55yo, pacemaker)		
Family/Social History = PFSH Pertinent PFSH = At least 1 specific item from either Past Family or Social Complete PFH = All		

NEW PATIENT VISIT

Patient Name: _____ DOB: _____ Date: _____

Pharmacy: _____ Location: _____

MEDICATIONS:

Please list **ALL** of the medications that you are taking at home. Include all prescription medications, non-prescription medications, vitamins, and supplements.

NAME OF MEDICATION	DOSAGE/STRENGTH	HOW MANY/HOW OFTEN
e.g. Lasix	*40 mg*	*1 tablet 3 times/day*

NEW PATIENT VISIT

Patient Name: _____ DOB: _____ Date: _____

Review of Systems:

The following questions relate to health problems you **HAVE** or **HAVE HAD** in the past. Please check **YES** or **NO**.

	Patient		Clinician
1. Constitutional:	YES	NO	
Weight Loss			
Weight Gain			
Fever			
Fatigue			
2. Eyes:			
Glaucoma			
Cataracts			
3. Cardiovascular:			
Chest Pain			
Shortness of Breath			
Edema (swelling)			
Palpitations			
4. Respiratory:			
Chronic cough/sputum			
Wheezing			
Asthma			
Bronchitis/Emphysema			
Tuberculosis			
Pneumonia			
5. Gastrointestinal:			
Stomach Ulcers			
Hiatal Hernia			
Hepatitis or Yellow Jaundice			
Gallstones or Gallbladder Disease			
Chronic Constipation or Diarrhea			
Diverticulitis			
6. Venous:			
Swelling in your legs, ankles or feet			
Pain, aching or heaviness in your legs			
Redness or warmth in your legs			
Masses or lumps in your legs			
Bulging varicose veins			
Previous blood clot in your legs			
7. Renal			
Kidney Stones			
Frequent Kidney or Bladder Infections			
Do you have to get up at night to urinate?			
How many times?			
Kidney Failure			

NEW PATIENT VISIT

Patient Name: _____ DOB: _____ Date: _____

Review of Systems: (cont.)

Patient | Clinician

8. Musculoskeletal:	YES	NO	Initial:
Gout			
Arthritis			
Cramping legs when walking			
9. Endocrine:			
Hypertension			
Diabetes			
High Cholesterol or fats in the blood			
Thyroid Problems or Goiter			
10. Neurological:			
Seizure Disorder			
Numbness			
Stroke			
11. Hematological			
Easy Bruising			
Bleeding			

Please note any other health problems you have, not covered by this list.

CLINICIAN ONLY BELOW

Review of Systems (ROS)

Problem Pertinent ROS:	Positive & Pertinent Negative responses related to problem
Extended ROS:	Positive & Pertinent Negative responses for 2 – 9 systems
Complete ROS:	Positive & Pertinent Negative responses for at least 10 systems

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family and/or Social History (PSFH)	Type of History	Codes #'s
Brief	N/A	N/A	Problem Focused	99212
Brief	Problem Pertinent	N/A	Expanded Problem	99213
Extended	Extended	Pertinent	Detailed	99214
Extended	Complete	Comprehensive		