

Dallas, Texas 75230

Phone: (972) 566-5700 Fax: (972) 566-5757

Thank you for choosing Heartl	Place for y	your car	diology	needs.	Your appo	intment is	
with Dr	on	/	/	at			
Please complete the attached no delay in your appointment	forms; as						ıre
 All paperwork <u>MUST</u> be <u>exceptions</u>! If we do not rescheduled. 							
 Please bring originals of copy. 	your insu	urance a	and driv	er's licei	nse so we i	may scan a	
 It is <u>YOUR</u> responsibility in nature) are either ser <u>one week before</u> your v 	nt to our o		-				С
 Bring all your medication appointment. 	ns with y	ou (incl	uding sı	uppleme	nts) to you	ır	

• If your insurance requires a **referral from your primary physician**, **it is** <u>your responsibility</u> to make sure and have it faxed to our office before your

appointment; or you may hand carry it to your appointment.

20180220-lsw

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



System Account#:	Heal	1Place			
	The Future Of	Cardiology Is Here			
How did you hear about HeartPlace? □ Physician Referral □ Advertisement □ Friend □ Other:			Date:		
Patient Information					
Name:last first	middle	Doctor:			
Social Security #:		Email Address: _			
Address:		City:	State:	z Zip: _	
Home Ph.: () E	Business Ph.: ()	-	_ Cell Ph.: ()	-
☐ Married ☐ Single ☐ Widow ☐ Divo	rced Age:	_ Date of Birth:			e 🖵 Female
Employer Name:		Employer Addres	SS:		
☐ Full-Time ☐ Part-Time ☐ Re	tired 🔲 Self-Em	oloyed	nt Full-Time	☐ Student F	Part-Time
Referring Physician:		Referring Physicia	an Ph.: (_)	
Primary Care Physician:		Primary Care Phys	sician Ph.: (_)	
nsured Name (If no insurance, respons		Polotionship			
Name: Social Security #:		Relationship: Date of Birth:			
		City:			
Address:		•		•	
Employer Name:	ousiness Fil ()	Employer Addres			
Notify In Case of Emergency		Employer Address	55		
1. Name: F		Ph:()_		_Wk:()_	_
2. Name:	Relationship:	Ph.()		_Wk:()_	-
nsurance Information – Copies of Insur					
Insurance 1:					
Address:			Ph.#: (
SS#: Police	sy #:	G	Group #:		
Insurance 2:					
Address:			Ph.#: (
SS#: Police	ey #:	G	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 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 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

y own free will.				
Patient Signature:	Date:	/	/	
Patient Name (Please Print):				
Witness Signature:	Date:	/	1	

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 P			
Patient Name (Print)			
Patient Signature			

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: Relationship _____ Phone (____)____ Relationship _____ Phone (____) Name Relationship _____ Phone (___)___ Name 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 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 ☐ Phone #: (_______ - ______ -I prefer to be contacted in the following manner: ☐ 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) @ . ☐ 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.

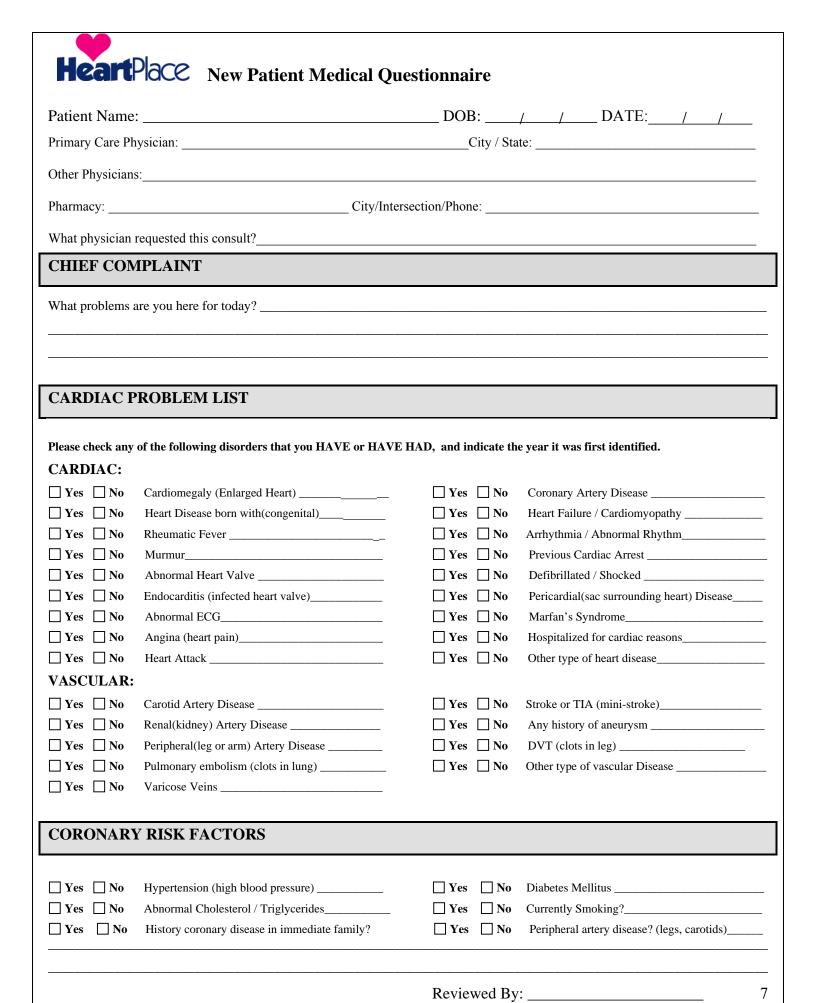
The import of Surescripts prescription history is not required for treatment. HeartPlace understands there may be situations, prescriptions, and medical history you do not want to share with your physician. Notifying your physician of all your medical history and currently prescribed medications is critical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

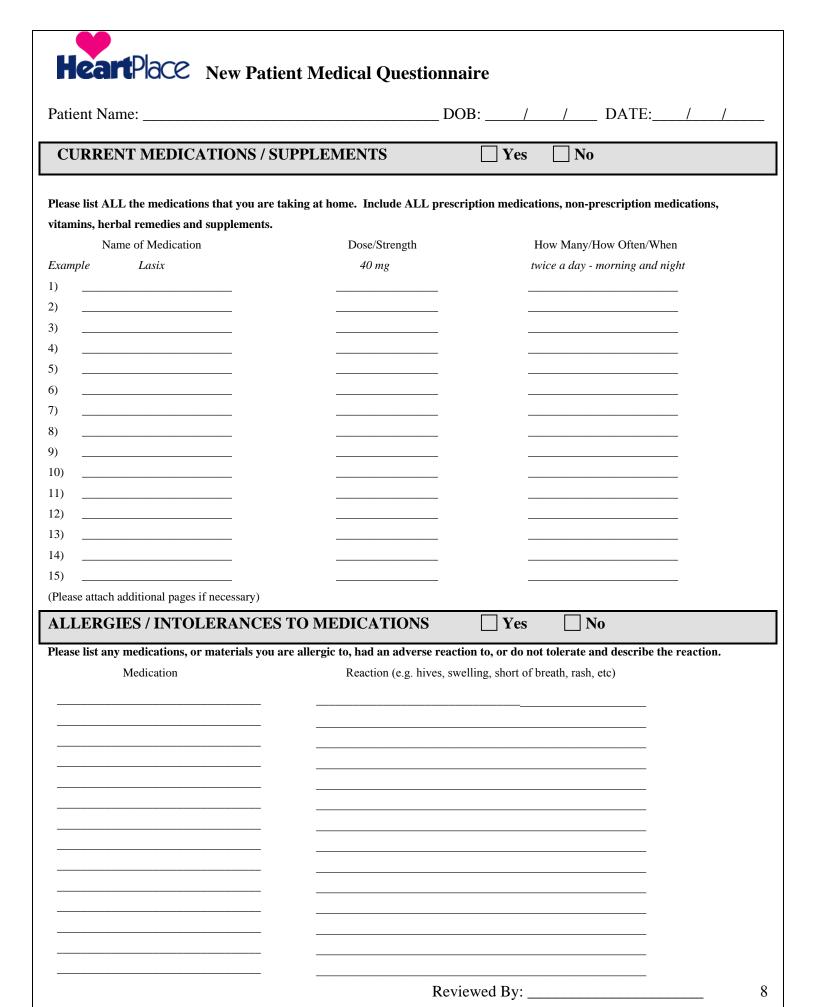
I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization") by Surescripts and the access and use of that information by HeartPlace, P.A. ("HeartPlace").

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	in the Surescripts electronic prescrip	otion data system.
Event on which this Authorization will expire: One year		
I understand that I may refuse to sign this Authorization, and that signing this form. I also understand that my Protected Health In recipient of the Protected Health Information pursuant to this Authorization at any time by notifying HeartPlace in writing, by HeartPlace or Surescripts took before it received the revocation of copy the Protected Health Information described on this Authorization will receive a copy of this Authorization after I sign it.	formation is subject to redisclosur Authorization. I understand that at if I do, it will not have any eff this Authorization. I understand	e to the authorized I may revoke this ect on any actions that I may see and
Will HeartPlace or any of its providers receive financial or in-kind health information described above? Yes No_X_	compensation in exchange for using	ng or disclosing the
	/	/
Signature of individual or individual's representative	Date	
Printed name of individual's representative	Relations	ship to patient
	/	/
Witness	Date	<u> </u>

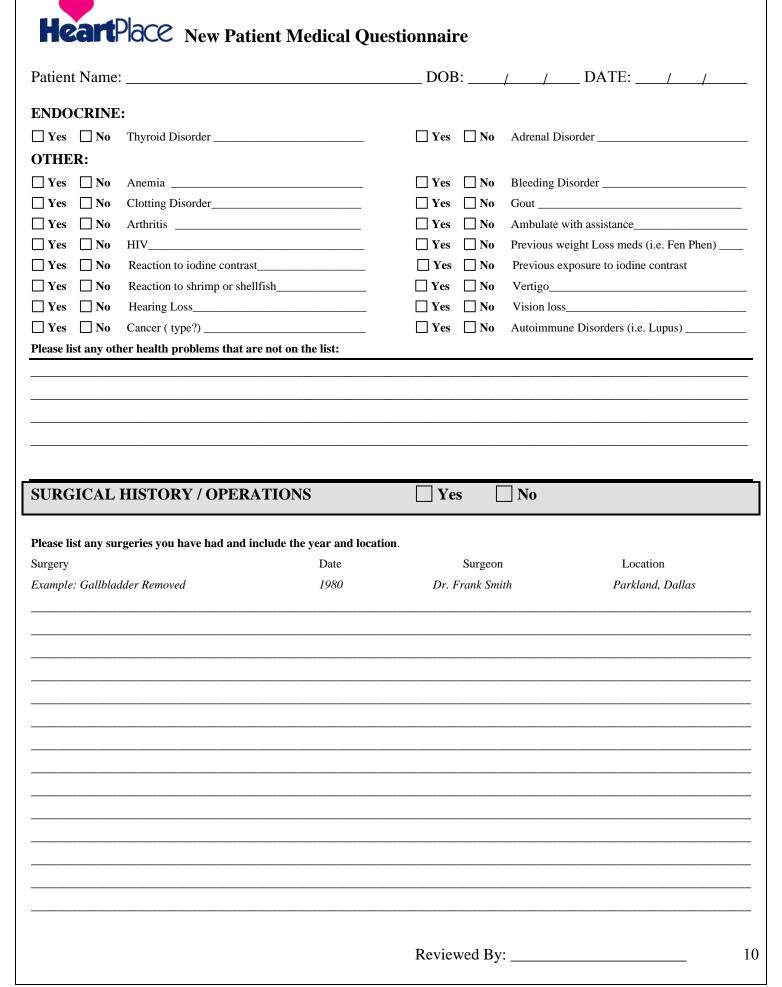
* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION *







	DOB:	_// DATE://_
ARDIAC PROCEDURES/DIAGNOSTIC TEST	ING	☐ Yes ☐ No
lease check that you have had or have not had any procedures / di	agnostic tests. Write the	year and the location of the test in the blanl
ndicated.	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		
	/E HAD, and indicate th	ne year it was first identified.
PULMONARY:	/E HAD, and indicate th	ne year it was first identified. Bronchitis
PULMONARY: Yes No Asthma		
PULMONARY: Yes No Asthma Yes No Emphysema / COPD	☐ Yes ☐ No	Bronchitis
PULMONARY: Yes No Asthma Yes No Emphysema / COPD Yes No Pneumonia	☐ Yes☐ No☐ Yes☐ No	Bronchitis
PULMONARY: Yes No Asthma	 ☐ Yes ☐ No ☐ Yes ☐ No 	Bronchitis
PULMONARY: Yes No Asthma	 ☐ Yes ☐ No ☐ Yes ☐ No 	Bronchitis Tuberculosis Sleep Apnea
PULMONARY: Yes No Asthma Yes No Emphysema / COPD Yes No Pneumonia GASTROINTESTINAL: Yes No Reflux(GERD)	 Yes	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia
PULMONARY: Yes No Asthma	☐ Yes ☐ No	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia Ulcers
PULMONARY: Yes No Asthma Yes No Emphysema / COPD Yes No Pneumonia GASTROINTESTINAL: Yes No Yes No Diverticulosis / Diverticulitis Yes No Liver Disease / Hepatitis Yes No Gallbladder Disease / Gallstones	☐ Yes ☐ No	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia Ulcers Gastritis
Yes No Emphysema / COPD	☐ Yes ☐ No	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia Ulcers Gastritis
PULMONARY: Yes No Asthma	☐ Yes ☐ No	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia Ulcers Gastritis Gastrointestinal Bleed
PULMONARY: Yes No Asthma Yes No Emphysema / COPD Yes No Pneumonia GASTROINTESTINAL: Yes No Yes No Diverticulosis / Diverticulitis Yes No Liver Disease / Hepatitis Yes No Gallbladder Disease / Gallstones RENAL / GENITOURINARY: Yes No Dialysis	Yes No	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia Ulcers Gastritis Gastrointestinal Bleed Prostate Disease
Yes	Yes No	Bronchitis
PULMONARY: Yes	☐ Yes ☐ No	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia Ulcers Gastritis Gastrointestinal Bleed Prostate Disease
PULMONARY: Yes	Yes No	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia Ulcers Gastritis Gastrointestinal Bleed Prostate Disease Kidney Disease / Elevated Creatinine Seizure Disorder
PULMONARY: Yes	Yes No	Bronchitis
PULMONARY: Yes	Yes No	Bronchitis
PULMONARY: Yes	Yes No Yes No	Bronchitis Tuberculosis Sleep Apnea Hiatal Hernia Ulcers Gastritis Gastrointestinal Bleed Prostate Disease Kidney Disease / Elevated Creatinine Seizure Disorder Dementia Anxiety Disorder





Patient Name:DOB:/DATE:/
SOCIAL HISTORY
Marital Status?: Single Married Divorced Separated Widowed Domestic Partner Previously Widowed
Number of sons?:Number of daughters?: Current hometown?:
With whom do you live?
Do you have a Medical Power of Attorney? Yes No Who?
Advanced Directives?: None Do Not Resuscitate Healthcare Proxy Living Will Date:/
Are you retired?: Yes No Current or Previous Occupation:
Primary language? Secondary language?
Leisure activities?: (Include any hobbies)
Home exercise equipment? Yes No If yes, what types:
Home blood pressure monitor? Yes No If yes, average readings:
Do you use tobacco? Yes Formerly Never
Type: How much: Start/Quit Dates Cigarettes per day Years Smoked? Quit Date?
Cigare per day Years Smoked? Quit Date?
Pipesper day Years Smoked?Quit Date?
Chewing tobacco per day Years Used? Quit Date?
Do you use alcohol? Yes Formerly Never
Describe your use? Rarely Social Daily Frequently Occasional Quit (when)
Type: How much:
☐ Beer cans per ☐ day ☐ wk ☐ mo ☐ yr
☐ Wine glasses per ☐ day ☐ wk ☐ mo ☐ yr
Spiritsglasses per day wk mo yr
Do you use caffeine? Yes Formerly Never
Type:
Caffeinated Coffee? cups per
Caffeinated Tea? cups per
Caffeinated Soda? cans per
Chocolate? servings per
Reviewed By:



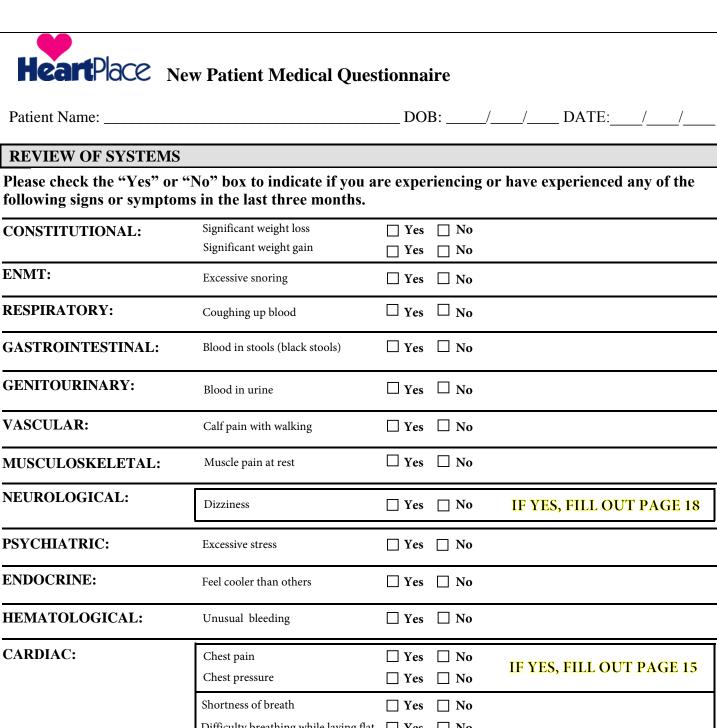
Heart Place New Patient Medical Questionnaire

Patient Name:			DOB:/_	/	DATE://
Do you use recre	ational drugs?	☐ Yes	Formerly		ever
Type:	How much:	Dates:			
☐ Marijuana	per	Started?	Qui	it?	Rehab?
Cocaine	per	Started?	Qui	it?	Rehab?
Methamphetamine	per	Started?	Qui	it?	Rehab?
Other	per day wk mo yr	Started?	Qui	it?	Rehab?
Exercise?					
No/Sedentary	Occasional Regular	- Ac	tive Lifestyle	Physic	cally Unable to exercise
Type:	How much:				Check any applicable:
Aerobics	How long? (Mins.)	How	often? (Per wk)		_ Started Exercising
☐ Cycling	How long? (Mins.)	How	often? (Per wk)		_
☐ Dancing	How long? (Mins.)	How	often? (Per wk)		_
Jogging	How long? (Mins.)	How	often? (Per wk)		_
Running	How long? (Mins.)	How	often? (Per wk)		_
Swimming	How long? (Mins.)	How	often? (Per wk)		_
Team sports	How long? (Mins.)	How	often? (Per wk)		_
☐ Walking	How long? (Mins.)	How	often? (Per wk)		_
☐ Weights	How long? (Mins.)	How	often? (Per wk)		_
Please choose the	e type of diet you are current	ly on?			
Type:	How well do you follow:				
Regular					
☐ Low fat/Chol	☐ Strictly ☐ Usually ☐	Occasionally	☐ Non –complian	t with diet	
☐ Low salt	Strictly Usually	Occasionally	☐ Non –complian	t with diet	
Diabetic	Strictly Usually	Occasionally	☐ Non –complian	t with diet	
Renal	☐ Strictly ☐ Usually ☐	Occasionally	☐ Non –complian	t with diet	
☐ No Added Salt	☐ Strictly ☐ Usually ☐	Occasionally	☐ Non –complian	t with diet	
☐ Weight Loss	Strictly Usually	Occasionally	☐ Non –complian	t with diet	
Low Carb	☐ Strictly ☐ Usually ☐	Occasionally	☐ Non –complian	t with diet	
☐ Vegetarian	☐ Strictly ☐ Usually ☐	Occasionally	☐ Non –complian	t with diet	

12

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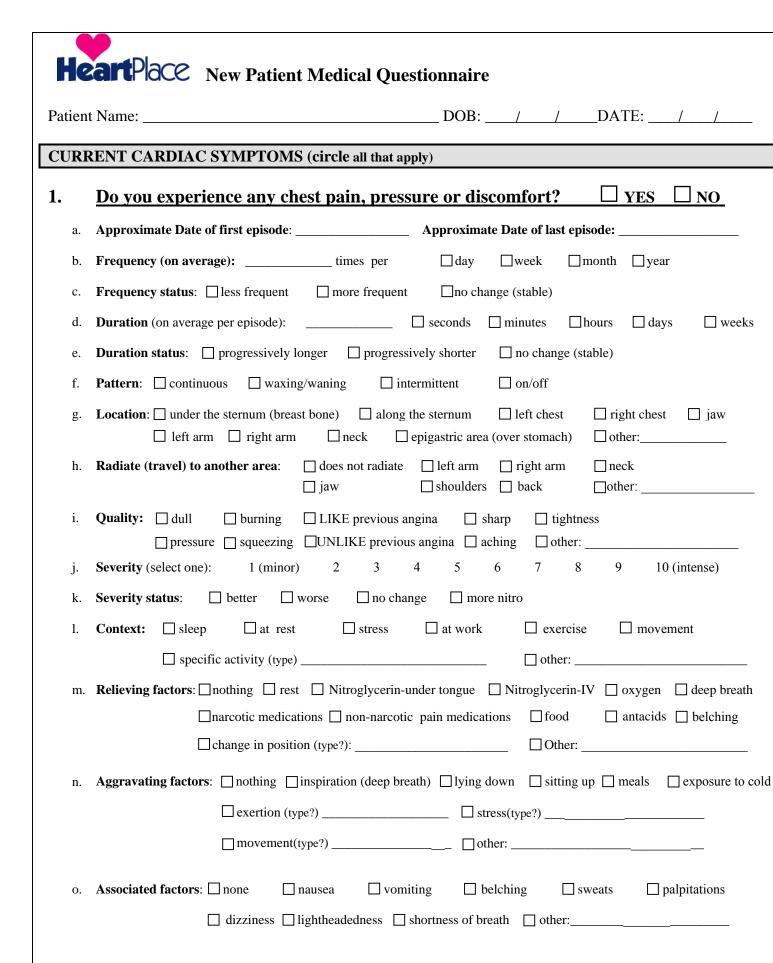
Reviewed By: _____



☐ Yes	☐ No	IF YES, FILL OUT PAGE 1	
☐ Yes	□ No		
☐ Yes	☐ No		
☐ Yes	☐ No	TE VEC ELLI OUT DACE 16	
☐ Yes	☐ No	IF YES, FILL OUT PAGE 1	
☐ Yes	□ No		
☐ Yes	□ No	IF YES, FILL OUT PAGE 17	
☐ Yes	□ No	IF YES, FILL OUT PAGE 18	
☐ Yes	□ No	IF YES, FILL OUT PAGE 19	
	☐ Yes	□ Yes □ No □ Yes □ No	

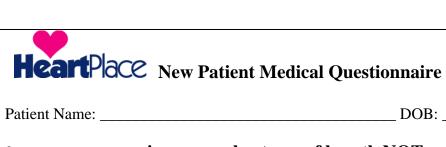
Reviewed By: _____

Any other reason why you need to see a cardiologist?:



Reviewed By:

15



Pat	ient	t Name: DOB:/ DATE:/
2.	I	Do you experience any shortness of breath NOT associated with chest pain? \Box YES \Box NO
	a.	Approximate Date of first episode: Approximate Date of last episode:
	b.	Frequency (on average):times per
	c.	Frequency status?
	d.	Duration (on average per episode)? ☐ minutes ☐ hours ☐ days
	e.	Duration status? ☐ progressively longer ☐ progressively shorter ☐ no change
	f.	Mode of onset? ☐ gradual ☐ sudden
	g.	Severity?
	h.	Severity status?
	i.	Context(When do you get short of breath?): ☐ at rest ☐ stress ☐ with activity (what type?)
	j.	How far can you walk before you get short of breath? □ yards □ blocks □ miles
	k.	Do you need to sleep on more than 1 pillow to breathe? ☐ NO ☐YES, How many pillows?
	1.	Do you wake up in the middle of the night short of breath? NO YES, How often?
	m.	Relieving factors: □ nothing □ fresh air □ nebulizers □ nitroglycerin □ rest □ oxygen □ sitting □ inhalers □ medications □ oral prednisone □ other:
	n.	Aggravating factors: □ nothing □ anxiety □ stress □ normal activities □ bending forward □ moderate activity (climbing stairs) □ strenuous activity(running) □ laying flat
	о.	Associated symptoms: none anxiety chest pain cough fever leg swelling wheezing palpitations lightheaded sputum other:
	1.	Do your legs swell? YES NO
	a.	Approximate Date of first episode: Approximate Date of last episode:
	b.	Frequency(on average): times per week month year
	c.	Duration:(on average) hours days weeks months
	d.	Severity: minimal mild mild to moderate moderate moderate to severe severe
	e.	What is the location of the swelling: foot ankle calf knee thigh other:
	f.	Context(when do your legs swell?): nothing laying flat sitting standing walking other:
	g.	What relieves the swelling: nothing compression stockings leg elevation lying flat sitting walking
		Reviewed By: 16

_	Do you experience any palpitations (rapid heart beat or skipped beats)? YES Quality: rare skipped beats occasional skipped beats flutter								
a.	sustained regular irregular rapid heartbeat other:								
b.	. Approximate Date of first episode: Approximate Date of last episode:								
c.	Frequency of palpitations(on average): times per day week month year								
d.	Frequency Status: more frequent less frequent no change (stable)								
e.	Duration (per episode): seconds minutes hours days								
f.	Duration status: longer shorter no change								
g.	Severity: minimal mild mild-to-moderate moderate moderate-to-severe severe								
h.	Severity status: increasing decreasing no change (stable)								
i.	Context: none sleep rest exertion(type?) other:								
j.	Aggravating factors: none anxiety stress caffeine alcohol Sudafed other-medications(type?) other:								
k.	Relieving factors: none cough neck massage bearing-down cold water to face exertion (type?) medications (type?) other:								
1.	Associated symptoms: none shortness of breath chest pain lightheadedness near-fainting fainting dizziness other:								
ì.	near-fainting fainting dizziness other:								
a.	near-fainting fainting dizziness other: Have you ever fainted (with loss of consciousness)? YES NO								
a. o.	Have you ever fainted (with loss of consciousness)? Have you ever felt dizzy or like you were going to faint or pass out? Quality (circle all that apply): floating imbalance lightheadedness								
a. b. a.	Have you ever fainted (with loss of consciousness)? Have you ever felt dizzy or like you were going to faint or pass out? Quality (circle all that apply): floating imbalance lightheadedness unstable horizon loss of consciousness (fainted) spinning								
a. b. a. b.	Have you ever fainted (with loss of consciousness)? Have you ever felt dizzy or like you were going to faint or pass out? Quality (circle all that apply): floating imbalance lightheadedness unstable horizon loss of consciousness (fainted) spinning Approximate Date of first episode: Approximate Date of last episode:								



atient	Name:				DOB:		/	DATE	l:	/ /
e.	Duration (on average):		seco	nds mi	nutes		hours	days	s
f.	Context:	no warning other pain coughing	palpitations bowel move urination		blood dra shortness ringing in	of brea	th	abdominal sitting to state other:	anding	
g.	Aggravating factors: none dehydration exercise(type?)				chang					
h.	Relieving f	actors:	none medications	lying down	sittin	_	Other:	rest		
i.	Associated	symptoms:	none slurred spec shortness o	confusion ech visual chan f breath		kness	chest	re-like activ pain	•	headache palpitations
	Any oth	ner reason	why you r	need to see a c	ardiologis	<u>st?</u>				
	Any oth	ner reason	why you r	need to see a c	ardiologis	<u>st?</u>				
	Any oth	ner reason	why you i	need to see a c	ardiologis	<u>st?</u>				
	Any oth			need to see a c			stionn	aire.		
Patient		Tha	nk you for ta				stionn	aire.		