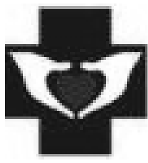


TEXOMACARE
SPECIALTY PHYSICIANS

Dear Patient:

Thank you for choosing TexomaCare Specialty Physicians! Our objective is to provide exceptional cardiac care for our patients, which is our utmost priority. Treatment received at TCSP is comprehensive and compassionate. You will be treated by our highly skilled and dedicated staff, which is committed to addressing your needs and providing education, training, and support in addition to the highest level of cardiac care available in the Texoma region.

At your visit, the cardiologist will obtain a thorough personal history; conduct a physical examination and order any office tests, if necessary. Depending on the outcome of his evaluation and examination, the physician will discuss with you his findings and the medical treatment plan options. In order for your visit to be efficient, we request the following:

Complete the attached **New Patient paperwork** in addition to bringing the following essential documents:

- Your picture ID or driver's license;
- Insurance card(s), primary and secondary;
- A list of your current medications with dosage amounts;
- Any test results or medical records that you have.

*Please note that we need any pertinent medical records at least one week prior to your appointment. There is a medical records release form included in the New Patient paperwork. We will need one signed for each provider or facility that has your records, so please make as many copies as necessary. If we do not receive all pertinent records prior to your scheduled appointment we may need to reschedule you to a later date.

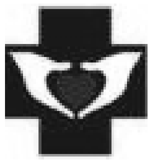
**Please arrive at least 30 minutes early for your appointment.

If you have any questions in regards to your appointment and/or the new patient packet, please do not hesitate to contact our office at your earliest convenience. If you reach a voicemail, please leave your name, date of birth, telephone number, and a detailed message and we will return your call in a timely manner.

We look forward to seeing you in our office and appreciate you for allowing us to be a vital part of your cardiac health.

Yours truly,

TexomaCare Cardiology



TEXOMACARE
SPECIALTY PHYSICIANS

PATIENT INFORMATION & MEDICAL SCREENING FORM

Today's date:

Demographics

Name - Last First MI		Date of Birth:
Address Line 1:		Gender: ☐Male ☐Female
Address Line 2:		SSN:
City: State: Zip:		Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other
Home Phone:	Okay to leave message? ☐Brief ☐Extended ☐None	Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Student
Cell Phone:	Okay to leave message? ☐Brief ☐Extended ☐None	Employer Name:
Work Phone:	Okay to leave message? ☐Brief ☐Extended ☐None	Occupation:(If retired, list previous occupation)
Which phone is primary? ☐Home ☐Cell ☐Work		
Email Address:		Ethnicity: ☐Caucasian ☐African American ☐Asian ☐Hispanic ☐American Indian ☐Other: ☐Do not wish to disclose
Primary Care Physician:	**Phone:**	
Preferred Pharmacy: Name/City	Phone:	Resident of Nursing Facility? ☐No ☐Yes If Yes, where:
Add'l/Mail Order Pharmacy: Name/City	Phone:	
Who may we thank for your referral to our practice?		

Emergency and HIPAA Contact Information

Check the HIPAA box if this person has permission to obtain your Private Health Information such as, appointment information, test results, medication information, demographic information, etc.

Name	Phone #	Relationship	Permission(s)
			☐ HIPAA ☐ Emergency
			☐ HIPAA ☐ Emergency
			☐ HIPAA ☐ Emergency

Insurance Information

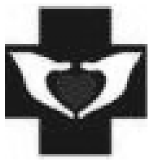
Primary Carrier:	Subscriber #:	Group #
Name of Insured	DOB of Insured	Relationship:
Secondary Carrier:	Subscriber #:	Group #
Name of Insured	DOB of Insured	Relationship:

Acknowledgement

Once signed, this document and the information herein becomes a permanent part of my medical record. By signing below I certify that the information entered above is true and correct to the best of my knowledge. It is my responsibility to notify TexomaCare Specialty Physicians (TCSP) immediately if there are any changes or updates to this information. I also understand that providing inaccurate or false information on this form could result in discharge from the practice and/or legal consequences. I also agree to the office policies of TCSP including financial responsibilities, which are available upon requested and/or listed on pages 5 and 6 of this packet.

____
Printed Name

____ _______________________________ ________________________
Signature of Patient or legal guardian Relationship Date



TEXOMACARE SPECIALTY PHYSICIANS

Patient Name:	DOB:

Current Medications

*List **ALL** current medications including over the counter medications/vitamins/herbals/supplements.*

Medication Name	Dosage	# Times Daily	Medication Name	Dosage	# Times Daily

Allergies to Medication & Food

Do you have any allergies to medication and/or food? ☐No ☐Yes, please explain below:

Type	Reaction	Type	Reaction

Social History

Do you exercise regularly? ☐No ☐Yes: type of exercise: How often:

Tobacco use:	☐Never	☐I quit – When? ☐ Packs per day? ☐ How long? ☐	☐I still smoke Packs per day? ☐ How long? ☐	☐Smokeless Tobacco No. of cans per day? ☐
Alcohol use:	How often do you drink: ☐Never ☐Occasionally ☐Socially ☐Daily	No. of drinks per week: Beer:__________ Wine:__________ Liquor:_________	Any alcohol-related personal or health problems: ☐Yes ☐No Explain:	Treatment for any alcohol-related problem: ☐Yes ☐No Drug-related problem? ☐Yes ☐No

Family History

Is your mother alive? ☐Yes ☐No – cause of death: Is your Father alive? ☐Yes ☐No – cause of death:

MEDICAL CONDITION	WHO?				MEDICAL CONDITION	WHO?			
	Grand-Parent	Parent	Sibling	Child		Grand-Parent	Parent	Sibling	Child
Arrhythmias (i.e., atrial fib, PAC, PVC, v-tach)					Aneurysm				
Congestive Heart Failure of Heart Failure					Cancer/type:				
Coronary Artery Disease					COPD/Bronchitis				
Heart Attack					Diabetes				
High Blood Pressure					High Cholesterol				
Peripheral Artery Disease					Stroke				
Sudden Cardiac Death					Other:				

TEXOMACARE
SPECIALTY PHYSICIANS

Patient Name:	DOB:

Medical Problems

*Please check the problems that you **CURRENTLY** have.*

- ☐ Angina
- ☐ Arterial Stenosis (i.e., carotid, renal
- ☐ Bleeding/Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack (myocardial infarction)
- ☐ Heart Valve Disease (which valve)
  - ☐ Mitral ☐ Tricuspid ☐ Aortic ☐ Pulmonary
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Rhythm (which one)
  - ☐ Atrial Fib ☐ Atrial Flutter
  - ☐ Ventricular Tachycardia
  - ☐ Premature Ventricular Contractions (PVC)
  - ☐ Premature Atrial Contractions (PAC)
  - ☐ Bradycardia ☐ Heart Block ☐ Other
- ☐ Peripheral Vascular Disease (ex: blood clots)
- ☐ Stroke
- ☐ Other:
- ☐ Arthritis
- ☐ Asthma
- ☐ Cataracts or ☐ Glaucoma
- ☐ Cancer / type:
- ☐ Colitis
- ☐ COPD / Bronchitis
- ☐ Depression
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ Gastritis/Ulcer
- ☐ GERD
- ☐ Hepatitis
- ☐ Hypothyroid OR ☐ Hyperthyroid
- ☐ Kidney Disease
- ☐ Migraine Headaches
- ☐ Seizures

Previous Surgeries

Type	Year	Type	Year

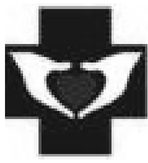
Have you had a cardiac catheterization/stent placement? ☐ Yes ☐ No
If yes, please provide date of placement, brand, size, and copy of your card (if applicable)

Do you have a	☐ Pacemaker or	☐ Implantable cardioverter defibrillator?	Date of Implant
Device product:	☐ Medtronic	☐ Boston Scientific ☐ St. Jude ☐ Other	

Previous Cardiac Procedures

Did you have any of the following procedures within the last year?

Procedure	Location	Procedure	Location
Echocardiogram	☐ Primary Care Office ☐ Hospital ☐ Other:	Renal Artery Ultrasound	☐ Primary Care Office ☐ Hospital ☐ Other:
Stress Test – walking on treadmill	☐ Primary Care Office ☐ Hospital ☐ Other:	Aorta Artery Ultrasound	☐ Primary Care Office ☐ Hospital ☐ Other:
Carotid Ultrasound	☐ Primary Care Office ☐ Hospital ☐ Other:	Chemical Stress Test – Adenosine; Lexiscan; Dobutamine; Cardiolite; Myoview; MUGA	☐ Primary Care Office ☐ Hospital ☐ Other:
Ultrasound of the Arteries and/or Veins in the legs and/or arms	☐ Primary Care Office ☐ Hospital ☐ Other:		



TEXOMACARE
SPECIALTY PHYSICIANS

OFFICE POLICIES

FINANCIAL & INSURANCE POLICY

If you have a TEXOMACARE SPECIALTY PHYSICIANS participating insurance: At the time of your appointment your copay, co-insurance and/or deductible will be collected. After **TCSP** bills your insurance, the balance remaining will be due, unless arrangement is made for payment with the Financial Counselor.

If you have insurance that TCSP does not participate in: You are responsible for payment of your bill at the time of service. **TCSP** will, however, file non-assigned claims to these insurance companies as a courtesy to you.

If you do not have insurance: At the time of your appointment, you will be expected to pay the discounted financial portion in full at time of service.

Authorization and Assignment of Benefits

Release of Medical Information Authorization: I authorize **TCSP** to release pertinent information about my medical condition for the purpose of securing health insurance benefits information, authorization or payment for cardiovascular services and tests. I will provide a current copy of any insurance identification cards policy numbers and demographic information to **TCSP** upon request. I also authorize **TCSP** to act as my representative and on my behalf to secure all authorization necessary from my insurance company regarding procedures or orders involving a surgical procedure or medical test performed by **TCSP** or an associate, including, if necessary, any appeal of a denial of benefit and in billing my insurance carrier for medications and/or supplies. I understand that I may revoke this authorization at any time by giving **TCSP** a written statement to withhold my personal and medical information from that time forward.

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to **TCSP** for any services or tests provided to me by **TCSP**.

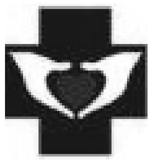
I understand and agree that a copy of this authorization and/or assignment of benefits, when signed by me, my authorized representative, or a legal guardian, may be sent to my insurance company or health care provider, if requested. A copy of this authorization and assignment of benefits shall be as valid as an original, and **TCSP** may refer to my signature on file regarding this authorization and/or this assignment of benefits.

By my signature, or an authorized signature, below, I understand and agree to the following:

- I am financially responsible to **TCSP** for any charges not covered by my health care benefits and for any portion of any charges denied by my health care benefits, in accordance with applicable law;
- I am financially responsible to **TCSP** for any nuclear pharmaceutical agent costs due to failure to re-schedule nuclear stress test appointment by 2:00 p.m. the business day prior to appointment day and/or not showing for the appointment;
- I am responsible to notify **TCSP** for any changes in my address and in my health care coverage;
- In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim and this may result in balances billed to me, such as deductibles, pre-existing clauses, etc.;
- I acknowledge receiving a copy of **TCSP** Notice of Privacy Practices;
- I understand that **TCSP** will endeavor to obtain authorization from my insurance provider to reimburse **TCSP** for services and/or tests that may be covered. However, there is no guarantee that **TCSP** will receive authorization or payment from my insurance provider.

PRESCRIPTIONS & SAMPLES REFILL POLICY

Prescriptions Refill: Plan on a 72-hour turn-around time for routine refills, and place call to the pharmacy to see if the medication is ready. When you request for a refill via online or telephone, please include all medications that need to be refilled within the next thirty days. When you come into the office, please ask for refills of prescription medications that you keep on hand. If you have mail-in pharmacy paperwork, we will be happy to assist you in completing the paperwork. However, it is the patient's responsibility to forward the paperwork or prescriptions to their pharmacy.
Sample Refill: Plan on a 24-hour turn-around time for sample refills.



TEXOMACARE
SPECIALTY PHYSICIANS

MEDICAL RECORD REQUEST POLICY

Please allow 3-5 business days to complete requests for medical records. **TCSP** may charge a reasonable and customary fee for all medical record requests that will be collected prior to records being released.

PATIENT RIGHTS & RESPONSIBILITIES

As a patient of **TCSP**, you have specific rights and responsibilities during your care. We believe that an informed patient, taking an active interest in his or her care, is happier emotionally and headed for a more satisfactory outcome. **TCSP**, its physicians and staff teat all persons without regard to race, creed, national origin, age or disability.

PATIENT RIGHTS

1. You will receive medical indicated care regardless of race, creed, gender, national origin or source of payment.
2. You have a right to considerate, respectful care as an individual at all times and under all circumstances.
3. You have a right to a safe environment for your treatment and care. You also have a right to care and accommodations that take into consideration physical disabilities that would otherwise impact your care.
4. You have a right to personal and informational privacy, within the law.
5. You have a right to complete information from your primary practitioner on your diagnosis, treatment, and any known prognosis.
6. You have a right to reasonable, informed participation in decisions on your care.
7. You may refuse treatment to the extent permitted by law, although it may result in the termination of the physician-patient relationship.
8. You are entitled to an explanation of **TCSP's** rules and regulations for patient conduct as well as the office's systems for handling patient complaints.

PATIENT RESPONSIBILITIES

1. You should provide, as fully as you can, accurate and complete information on present complaints, past illnesses and hospitalizations, medications and other matters regarding your health. You are also responsible for reporting any changes to your practitioner.
2. You should tell the staff if you do not understand explanations of your care or what is expected of you.
3. You are responsible for following the treatment plan your physician recommends.
4. You are responsible for your actions if you refuse treatment or do not follow your physician's orders.
5. You are responsible for having your bill paid as promptly as possible.
6. You are responsible for following **TCSP's** rules for patient care and conduct.

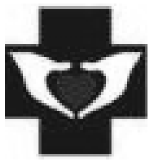
Mid-Level Practitioners

Nurse practitioners (NPs) and physician assistants (PAs) are qualified health care professionals who provide care and treatment while working under the close supervision of a doctor. They have been certified to perform many of the same tasks as a doctor.

By signing below, I hereby consent to treatment necessary for the care of the patient indicated on this form. I certify that the information I have provided is truthful, correct and complete, and I understand and agree to the terms of this authorization and assignment of benefits. I acknowledge that any inaccurate information provided or omission of accurate information may delay the processing of my services and tests and shall result in **TCSP** *billing me for the services and tests provided.*

____
Patient Name (please print)

____ ______________________ ______________________
Signature of Patient or Legal Guardian Relationship Date



TEXOMACARE SPECIALTY PHYSICIANS

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Date:	
Patient Name:	DOB:

The Health Insurance Portability and Account Act (HIPAA) of 1996 was enacted to regulate the use and disclosure of Protected Health Information (PHI). Your PHI will be used by TexomaCare Specailty Physicians (TCSP) or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day healthcare operations of our practice as permitted or required by law.

You have the right to request a restriction, in writing, of your PHI at any time. However, TCSP may or may not agree to your request to restrict the use or disclosure of you PHI. Patients may also request we communicate their PHI to spouses, relatives, or friends or other healthcare entities. If you request this right, we are required to have a completed authorization on file prior to releasing your PHI.

The PHI covered by this authorization includes all of the following (check all that apply):

☐Appointment Information ☐Test Results ☐Physicians Orders ☐Medication Information

☐Questions regarding your current health status ☐Pre-Procedure Instructions ☐Demographic Information

You authorize TCSP to obtain or release your PHI to the following persons:

Name:	Phone #:	Relationship:
1.		
2.		
3.		

You authorize TCSP to obtain or release your PHI to the following physicians or facilities:

Name of Provider or Facility	Phone #:
1.	
2.	
3.	

If you would like our office to communicate your PHI to your primary care physician or referring physician, please indicate by checking the appropriate box: ☐Yes ☐No

You also have the right to request to receive confidential communications from us by alternative means other than speaking with you over the telephone. These means may not be secure if others have access to them. If you request this right, we are required to have a completed authorization on file prior to releasing your information.

The information covered by this authorization includes communicating via the following means: (Please check the box by each method you wish our practice to communicate with you.)

☐Answering Machine at Home ☐Voicemail on Cell Phone ☐Voicemail at Work ☐Secure Email

Signature below is only acknowledgement that you have read and understood the implications of this authorization to release your PHI to others designated above, to your referring physician and/or communicate by alternative means.

____
Patient Name (please print)

____ ______________________ _____________________
Signature of Patient or Legal Guardian Relationship Date

____ _____________________
Signature of Witness Date