TEXOMACARE
Specialty Physicians

Patient History Questionnaire

Patient Name: _____ DOB: _____ Date: _____
Doctor(s) who sent you: _____ Primary Care Physician: _____
Cardiologist: _____ List all Doctors you see: _____
_____
Chief Complaint: _____

Doctor's Note	Brief 1-3 Elements	Brief 1-3 Elements	Extended 4+ Or 3 Inactive	Extended 4+ Or 3 inactive

II. History of Present Illness (HPI) _____

_____
_____
_____

Doctor's Note On PFSH	NONE	NONE	NONE	NONE

III. Past, Family & Social History

A. Medical History of the Patient ONLY (Please check those medical problems that apply)

	Patient	Family		Patient	Family		Patient	Family
High Blood Pressure			Diabetes			Heart Trouble		
Respiratory Problem			Stroke			Cancer		
Bleeding Problems			HIV/AIDS			Hepatitis		
PVD			High Cholesterol			Other		

Current Medications:

1._____ 5. _____ 9. _____
2._____ 6. _____ 10. _____
3. _____ 7. _____ 11._____
4. _____ 8. _____ 12. _____

Allergies: _____
Past Hospitalizations/Medical/Surgical History and approximate date: _____
_____
_____

B. Family History (please list any medical problems in your relatives)
Father: _____ Mother: _____ Siblings: _____
Others: _____

C. Social History (Please check those medical problems that apply)

1. Martial: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
2. Tobacco: ☐ Never ☐ Current (packs\day) _____ Quit/When? _____
3. Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily How Much? _____
4. Drug Use: ☐ Never ☐ Type & Frequency _____

TEXOMACARE

Patient: _____ Date of Birth: _____

Consent for Treatment

The patient agrees and consents to general medical treatment by TexomaCare professionals and consents to the review and use of his/her medical records which includes the history from RXHub by any TexomaCare physician.

Understanding of Financial Responsibility

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment of Insurance Benefits

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician or extender. I further understand and agree that this agreement remains in force until revoked by me in writing.

HIPPA-Notice of Privacy Practices

This notice describes how medical information about the patient may be used and disclosed and how I can access to this information. Per my signature below, I acknowledge that the TexomaCare Notice of Privacy Practices has been provided to me if requested.

Signature: _____ **Date:** _____

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Authorization

For Use and Disclosure of Information

Patient Name: _____

TEXOMA CARDIOVASCULAR SURGEONS, LLP has been authorized to use and/or disclose the following protected health information (PHI) on the above notes patient, which may include sensitive information such as HIV/AIDS tests, alcohol & drug abuse treatment records, mental health records, to (Name of entity and/or person to whom information is to be used/disclosed).

_____
_____
_____
_____
_____

This PHI will be used or disclosed for the treatment of the patient or reimbursement of the insurance.

I understand that I have the right to revoke this authorization at any time by submitting a written request to Texoma Cardiovascular Surgeons, LLP. Furthermore, I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal privacy regulations.

I also understand that I have the right to refuse to sign this authorization and that my treatment or eligibility for benefits will not be conditional upon this authorization.

The use or disclosure requested in this authorization will result in direct or indirect compensation to Texoma Cardiovascular Surgeons, LLP from a third party (if applicable)

Patient Signature or Representative: _____ Relationship: _____

Printed name of Patient or Representative: _____ Date: _____

Witness: _____ Date: _____

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Financial Policy

Patient Name: _____ **DOB**: _____

Thank you for choosing Texoma Cardiovascular Surgeons, LLP as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you read and understand our financial policy.

Insurance

Texoma Cardiovascular Surgeons, LLP will bill your insurance carrier with the information that you provide to our office. It is the patient's responsibility to provide complete and accurate information for billing purposes. If your address, contact information or insurance coverage changes, please provide our office with updated information as soon as possible. If you fail to provide accurate insurance information, your insurance company may deny your claim. If your claim is denied, you will be financially responsible for the entire amount. If you are covered by an HMO/Managed Care Health Plan, it is your responsibility to know and understand your insurance plan. If a referral/authorization is required for a specialist visit, it is your responsibility to obtain the referral/authorization for your primary care physician. In this event you change your primary care physician during treatment with Texoma Cardiovascular Surgeons, LLP. you will be responsible for obtaining a new referral/authorization from your current primary care physician. It is your responsibility to know and understand the level of services covered by your insurance company.

Co-Pays/Co-insurance/Deductibles

Co-pays, coinsurance and deductibles are due at the time services are rendered. Please be advised that some services provided by our physicians may NOT fall under your office copay amount. This amount may fall under your coinsurance or towards your annual deductible. Texoma Cardiovascular Surgeons, LLP. will file your claim with your insurance carrier; however, based on your benefit plan and provisions you will be financially responsible for any balance due after your insurance pays.

Uninsured/Private Pay/High Deductible Health Insurance Plans

If you do not currently have insurance or participate in a high deductible health insurance plan, and it is determined that you will require a surgical procedure, you will need to coordinate a payment plan with our business office. A payment agreement must be agreed upon prior to any surgical procedures. If you are a patient following up from the hospital and you do not have health insurance, you will need to coordinate a payment plan with our business office.

Medicare Patients

Texoma Cardiovascular Surgeons, LLP physicians are participating providers with the Medicare Program. We accept the Medicare allowable as payment; however you are responsible for any co-pays, coinsurance, and/or deductibles that apply. If you have a secondary or supplement insurance (Medigap), please provide our office with your insurance information so we can file with your secondary/supplement carrier. Please be advised that Medicare and secondary carriers DO NOT cover some procedures. In this rare instance, you may be asked to sign a Medicare Waiver Form, which states that you understand you will be financially responsible for "NON-COVERED" services.

Administrative Fees

Texoma Cardiovascular Surgeons, LLP may assess an administrative fee up to $35 for administrative forms to be completed and signed by your physician. These forms may include disability insurance forms, return to work forms, and any other form requiring completion and a signature from your physician.

I ACCEPT the TERMS of the FINANCIAL POLICY

_____ _____

Patient Signature Date