TEXOMACARE
Specialty Physicians

Patient Information & Medical Screening Form

Name: ______________________________ Date of Birth: ____________________

Social Security Number: ____________________

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Other

Home Address: __________________________ City: __________ ST: _____ Zip: ________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Which Phone Number is Primary? ☐ Home ☐ Cell ☐ Work

E-mail address: ____________________ Preferred Method of Contact: ☐ Phone ☐ Email

Employer Name: ______________ Occupation: __________ If retired, list previous occupation

Primary Care Physician: ____________________ Preferred Pharmacy: ______________

Are you a resident of nursing facility? ☐ No ☐ Yes: where? __________________________

Is there someone we may thank for your referral to our practice? ________________________

Emergency Contact Information

Name: ____________________ Phone #: ______________ Relationship: ______________

Name: ____________________ Phone #: ______________ Relationship: ______________

Primary Insurance Information

Insurance Carrier: ________________ Subscriber #: ________________ Group #: ________

Name of Insured: ______________ DOB of Insured: ____________ Relationship: __________

Secondary Insurance Information

Insurance Carrier: ________________ Subscriber #: ________________ Group #: ________

Name of Insured: ______________ DOB of Insured: ____________ Relationship: __________

Patient Name:____________________________

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

Medication Name	Dosage	# Times Daily

Allergies to Medication and Food

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

Patient Name:____________________________

Medical Problems: *Please check the problems 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

☐ 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

☐ Other: ____

Previous Surgeries

	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? Device product: ☐ Medtronic ☐ Boston Scientific ☐ St. Jude ☐ Other	Date of implant?

Patient Name:___________________________

Previous Cardiac Procedures: ***Did you have any of the following procedures within the last year?***

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

Family History

Is your mother alive? ☐ Yes ☐ No–cause of death _______ *Is your father alive?* ☐ Yes ☐ No–cause of death______

Does anyone in your immediate family have or had the following?

X	Medical Condition	Who?	X	Medical Condition	Who?
	Arrhythmias (i.e., atrial fib, PAC, PVC, v-tach)			Aneurysm	
	Congestive Heart Failure or 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:	

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 # of cans per day?
Alcohol use?	How often do you drink? __ Never __ Occasionally __ Socially __ Daily	Number of drinks per week? Beer: ____ Wine: ____ Liquor: ____	Any alcohol-related personal or health problems? __ Yes __ No	Treatment for any alcohol-related problem? __ Yes __ No Drug-related problem? __ Yes __ No

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OFFICE POLICIES

FINANCIAL & INSURANCE POLICY

If you have a TCSP 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 an 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 TexomaCare Specialty Physicians 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 determine 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 AND 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.
Samples Refill: Plan on a 24-hour turn-around time for sample refills.

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 TEXOMACARE SPECIALTY PHYSICIANS, 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. TEXOMACARE SPECIALTY PHYSICIANS, its physicians and staff treat all persons without regard to race, creed, national origin, age or disability.

PATIENTS RIGHTS

1. You will receive medically 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 know the identity and professional status of your caregivers and to know which physician is primarily responsible for your care.
6. You have a right to complete information from your primary practitioner on your diagnosis, treatment and any known prognosis.
7. You have a right to reasonable, informed participation in decisions on your care.
8. You have a right to visitors and to telephone or written communication with others.
9. You have a right, at your own expense, to consult a specialist.
10. You may refuse treatment to the extent permitted by law, although it may result in the termination of the physician-patient relationship.
11. You will not be transferred to another facility without a full explanation of the need and an explanation of alternative. The other facility must also accept you before your transfer.
12. You are entitled to complete information from your practitioner on any continuing health care requirements following your discharge.
13. You have a right to an itemized and detailed explanation of your bill for services.
14. 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.
15. You are entitled to information about Advanced Directives and Durable Power of Attorney for healthcare. You should share this information with your family and physicians.

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.
7. You are responsible for being considerate of the rights of other patients and office personnel, including controlling noise, the number of visitors and no smoking.

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.

Signature

Date