

EXCEL CARDIAC CARE

PATIENT REGISTRATION INFORMATION

Today's Date: _____

Legal Last Name:	_____	Legal First Name:	_____				
Middle Name:	_____	Suffix:	_____	First Name used:	_____		
DOB:	_____	SSN:	_____	Sex:	_____	Marital Status:	_____
Address:	_____	City:	_____	State:	_____	Zip:	_____
Mobile Phone:	_____	Home:	_____	Work:	_____		
Preferred Phone (Choose One):	<u>Mobile</u>	<u>Home</u>	<u>Work</u>	Email Address:	_____		
Consent to Text (Choose One):	<u>Yes</u>	or	<u>No</u>				
Language preferred if other than English (Choose One):	<u>Spanish</u>	Other:	_____				
Race (Choose One):	<u>White</u>	<u>African American</u>	<u>Asian American</u>	<u>Native American</u>	<u>Pacific Islander</u>	<u>Other</u>	
Ethnicity (Choose One):	<u>Non-Hispanic/Latino</u>	<u>Hispanic/Latino</u>					
Preferred Pharmacy:	_____						

EMERGENCY CONTACT

Last Name:	_____	First Name:	_____
Relation to Patient:	_____	Phone:	_____

INSURANCE INFORMATION

Primary Insurance:

Policy Holder Name (if different from patient):	_____	DOB:	_____
Name of Insurance:	_____	Plan Type (HMO, PPO, etc.):	_____
ID/Certification Number:	_____	Policy/Group Number:	_____
Insurance Claims Address:	_____	Phone:	_____

Secondary Insurance:

Policy Holder Name (if different from patient):	_____	DOB:	_____
Name of Insurance:	_____	Plan Type (HMO, PPO, etc.):	_____
ID/Certification Number:	_____	Policy/Group Number:	_____
Insurance Claims Address:	_____	Phone:	_____

CONSENT FOR TREATMENT

I authorize Excel Cardiac Care to examine me (or the patient for I am legally responsible) and to do any tests that may be needed to make a diagnosis and to provide treatment. I consent to necessary office or other outpatient treatment after being properly informed of alternatives, benefits, and risks.

Patient/Legal Guardian signature

Relationship of Legal Guardian

Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Release of information for purpose of payment. I authorize Excel Cardiac Care to release to any billing agency, insurance company, health plan, or governmental agency such medical information that may be required to process my claim for payment of the medical bill.

Release of information for purpose of treatment. I further authorize Excel Cardiac Care to release appropriate medical information to any doctor, hospital, or other healthcare facility that has or will participate in my (the patient's) care. I authorize a photocopy, facsimile, or other electronic transmission of the above Assignments, Authorizations, and Releases to be used in place of the original until and unless I send written notice to the contrary to the offices of Excel Cardiac Care.

Release of information for purpose of operations. I further authorize Excel Cardiac Care to release or use all of my (the patient's) information necessary for ongoing operations of this office, including (but not limited to) the credentialing process, peer review, accreditation, and compliance with all federal and state laws.

I further authorize any other doctor, hospital, or health care facility to release to Excel Cardiac Care any medical information concerning my (the patient's) illness or injury.

Patient, Legal Guardian signature

Relationship of Legal Guardian

Date

ASSIGNMENT OF BENEFITS

I authorize any insurance company, or third-party payer (or Medicare) to whom a claim for payment has been submitted to pay any eligible benefits directly to Excel Cardiac Care. I hereby authorize payment to go directly to Excel Cardiac Care of medical benefits payable by my insurance company (and/or Medicare) and understand that I am responsible for any charge not covered by the terms of my insurance policy.

I hereby assign Excel Cardiac Care full rights to represent my (the patient's) interests in any complaints of appeals of denial of benefits or reimbursement to the Texas Department of insurance (State Insurance Commissioner). I hereby authorize said assignee Excel Cardiac Care to furnish these agencies such information as may be necessary to support such complaints or appeals.

I agree I cannot revoke the FINANCIAL AGREEMENT or the INSURANCE ASSIGNMENT at any time while any portion of the medical bill remains unpaid.

I have read, understand, and do hereby agree to the terms of the forgoing CONSENT FOR TREATMENT, AUTHORIZATION FOR RELEASE OF INFORMATION and ASSIGNMENT OF BENEFITS. I also certify that the PATIENT INFORMATION and INSURANCE INFORMATION I have provided is true and accurate to the best of my knowledge.

Patient, Legal Guardian signature

Relationship of Legal Guardian

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed and understand Excel Cardiac Care **Notice of Privacy Practices** which explains how my medical information will be used and disclosed. A copy of Notice of Privacy Practices was made available to me.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices.

To release any information regarding patient to patient’s relatives or agents, the practice must have permission from the patient. I hereby authorize the following person (s) to be involved with and receive information pertaining to my medical care.

Name

Relationship

Patient’s Printed Name

Date

Patient/Legal Guardian Signature

Relation of Legal Guardian

EXCEL CARDIAC CARE FINANCIAL POLICY

Excel Cardiac Care recognizes the importance of the successful operation of our practice. It is our hope that you will understand that our financial policy is a necessary part of assuring the financial resources required to maintain vital health care services for our patients and the community. Our goal is to set standards that will provide our patients with the highest quality of medical care.

- We participate with most insurance plans; however, it is your responsibility to know if we participate with your particular plan. We will bill your insurance company for medical services provided by our practice. It is the patient's responsibility to make sure we have the correct insurance information.
- **CO-PAYMENT, CO-INSURANCE, AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME OF SERVICE PER YOUR INSURANCE CONTRACT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE BILLING STAFF.** We reserve the right to reschedule the appointment in case the patient is unable or unwilling to pay the amount due. We will bill the patient for any balances due from Co-payments, Co-insurance or Deductibles and expect all balances to be paid within the initial billing cycle.
- If your insurance has referral requirements, you are required to have prior authorization or a referral from your Primary Care Physician (PCP) prior to your visit.
- If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you on an unassigned basis as a courtesy. This means your insurer may send the payment directly to you. Therefore our charges for your care and treatment are due at the time of service. We do not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay; however, the doctor's fees may be more than what the insurance company will pay. Any balance not covered by the insurance company becomes your responsibility.
- All health plans are not the same and do not cover the same services. Certain services performed by our office, for your benefit, may not be covered by your insurance plan. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility.
- A certain amount of time and preparation goes into your visit with our office. If you are unable to keep your appointment, please give us at least 48 hour notice. **WE RESERVE THE RIGHT TO CHARGE FEES FOR EITHER A MISSED APPOINTMENT OR APPOINTMENT NOT CANCELLED WITH A 48 HOUR NOTICE. THIS FEE IS \$200 FOR NUCLEAR STRESS TEST. FOR ALL OTHER APPOINTMENT TYPES THE FEE IS \$50.**
- Patients with no insurance coverage will be recognized as "Self Pay" patients. We expect all Self Pay patients to pay at the time of service unless prior arrangements have been made with the billing staff.
- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For your convenience, we accept VISA, MasterCard, American Express, Discover, Diners Club, JCB, Union Pay and personal checks. Returned checks will incur a \$30 service charge.
- Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid without contacting the billing department to discuss payment options, the account may be turned over to an outside collection agency.

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO ALL THE TERMS CONTAINED HEREIN. I ALSO UNDERSTAND AND AGREE THAT THE TERMS MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Patient's Printed Name

Date

Patient/Legal Guardian Signature

Relationship of Legal Guardian

Social History:

Current Tobacco Use: Yes or No; If no, please answer the following:

Did you ever smoke? Yes or No

How many years approximately? _____

How many packs per day? _____

Smokeless Tobacco? _____

Current Alcohol Use:

Occasional

Socially

Moderate

Heavy

IV Drug or Illegal Drug Use:

Yes

No

Caffeine Intake:

None

Low

Moderate

Heavy

Salt Intake:

None

Low

Moderate

Heavy

Exercise:

None

Low

Moderate (2-3 days per week)

Heavy (more than 3 days per week)

General Stress Level:

Low

Moderate

High

Occupation: _____

Number of children: _____

Surgical History:

- Aneurysm surgery. Date: _____
- Rhythm related Cardiac Ablation. Hospital: _____ Date: _____
- Pacemaker. Device brand: _____ Date placed: _____
- Defibrillator. Device brand: _____ Date placed: _____
- Valve surgery or repair. Aortic Mitral Tricuspid; Date: _____
- Atrial septal defect repair
- CABG (Coronary Bypass) Hospital: _____ Date: _____
- Cardiac Catheterization – No Stent; Hospital: _____ Date: _____
- Cardiac Catheterization – Stent; Hospital: _____ Date: _____
- Carotid Surgery Left Right Hospital: _____ Date: _____
- Vascular Surgery Left Right Hospital: _____ Date: _____
- Tonsillectomy/Adenoidectomy
- Gall bladder removal
- Hernia surgery
- Abdominal surgery
- Appendix removal
- Other: _____
- Other: _____

Past Medical History:

- | | |
|----------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hyper / Hypo Thyroid Disease |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Heart attack? Year: _____ |
| <input type="checkbox"/> Atrial flutter | <input type="checkbox"/> Pacemaker Brand: _____ |
| <input type="checkbox"/> Blood clots in legs | <input type="checkbox"/> Defibrillator Brand: _____ |
| <input type="checkbox"/> Blood clots in upper extremities | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Coronary heart disease | <input type="checkbox"/> Blood clot in lungs |
| <input type="checkbox"/> Congenital heart disease (from birth) | <input type="checkbox"/> Valve problem - Aortic |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Valve problem - Mitral |
| <input type="checkbox"/> Diabetes Type I or Type II | <input type="checkbox"/> Valve problem - Tricuspid |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Vein issues in leg |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other _____ |

EXCEL CARDIAC CARE

Phone: (817) 518-9005
Alt. Phone: (940) 799-3580
Fax: (817) 518-9015

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This is a release form for authorization of medical information to be transferred between health care providers, health insurance companies and any other party involved in my medical care.

Patient Full Name: _____

Date of Birth: _____

I authorize the following facilities/hospitals and doctor(s) to release all medical information to Excel Cardiac Care to better manage my health.

This request includes hospital summaries, echocardiogram reports, cardiac catheterization reports, vascular reports, laboratory reports, electrocardiograms, physician progress notes, and any other healthcare information relating to my health condition.

List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Date

Patient/Legal Guardian Signature

Relation of Legal Guardian