Patient Information

Seton Heart Institute

First Name: | M.I. | Last Name:

Address: | City: | State: | Zip Code:

Phones: (H) | (W) | (C)

DOB: | Sex: Male Female | SSN: | Marital Status:

Ethnicity: | Race: | Language:

Emergency Contact/Phone:

Primary Care Physician: | Phone:

Referring Physician: | Phone:

RESPONSIBLE PARTY

First Name: | M.I. | Last Name:

Address: | City: | State: | Zip Code:

Phones: (H) | (W) | (C)

DOB: | Sex: Male Female | SSN: | Relationship:

Email Address:

PHARMACY INFORMATION

Pharmacy Name: | Pharmacy Phone #:

PRIMARY INSURANCE INFORMATION

Insurance Company: | Policy Holder Name:

Policy/Member ID #: | Relationship to Patient: | DOB:

SECONDARY INSURANCE INFORMATION

Insurance Company: | Policy Holder Name:

Policy/Member ID #: | Relationship to Patient: | DOB:

APPOINTMENT REMINDERS

Preferred Time: | Preferred Phone:

REFERRAL SOURCE (Please Check One)

☐ Newspaper ☐ TV ☐ Radio ☐ Direct Mail ☐ Magazine ☐ Website/Internet ☐ Billboard ☐ Event ☐ Friend/Family ☐ ARC Referral

Other:

Do you have an advanced directive? (Please Check One) Yes No

MEDICAL INFORMATION: I authorize the physicians of this office to release any information they have acquired in the course of my or my child's treatment to my insurance company or companies or any third party payor so that they may obtain payment for medical services rendered.
INSURANCE AUTHORIZATION: I hereby authorize the physicians or staff of this office to furnish information to my insurance carries concerning myself or my child's illness and treatments.
ASSIGNMENT OF BENEFITS: I authorize the insurance company or any third party payor to pay any benefits due directly to this office should they accept assignment on my claim. **I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

Signature: | **Date:**

Authorization for Release of Patient Information

Seton Heart Institute

Patient Name _____ Date of Birth _____ MRN/Acct # _____

I, the patient named above or his/her parent/legal representative, hereby authorize the Clinic named above to:

☐ **Release To:** ☐ **Obtain From:**	Date Range
Name of Entity/Person:	From: To:
Address:	Phone:
City, State & Zip:	Fax:

The following individually identifiable health information for the purpose(s) identified below:

Information (check one or more):		**For the Purpose Of (check at least one):**	
☐ Complete medical record	☐ Billing records	☐ Continuing Care by Other Provider	
☐ Immunization record	☐ Medication list	☐ Disability	☐ Insurance
☐ Lab/pathology reports	☐ Diagnostic reports	☐ Legal/Attorney	☐ School
☐ Alcohol/Substance Abuse records (42 CFR Part 2)		☐ Patient Request	
☐ Other (Specify): _____		☐ Other (Specify):	

NOTICE TO RECIPIENT: Federal rules prohibit further disclosure by the recipient of any alcohol or substance abuse records released under this Authorization unless the recipient has received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Acknowledgments. I understand and acknowledge that:

1. Individually identifiable health information may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), genetic testing, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.
2. I do not have to sign this Authorization and that my refusal to sign will not affect my ability to receive health care services or items.
3. The entity or person receiving information under this Authorization may not be subject to HIPAA or state privacy rules and the information released may no longer be protected by federal or state privacy rules.
4. I may cancel this Authorization at any time by submitting a written notice of revocation to the Clinic at the address listed in the upper left hand corner. The revocation will not affect any use or disclosure by the Clinic before receipt of the written revocation.

EXPIRATION:

Authorization expires 180 days from the date signed or the following: _____

(Date or Event)

_____ Date _____ Signature of Patient or Patient's Representative _____ Printed Name of Patient's Representative

Relationship to Patient (if requestor is not the patient) ☐ Parent ☐ Legal Guardian* ☐ Other*: _____

*Attach legal document

****

FOR STAFF USE ONLY

Date request received: _____ **Date request completed:** _____ **# of pages released:** _____

Staff Name: _____ ☐ **Paper Copies** ☐ **Electronic Copy**

REV0114

Notice of Privacy Practices

Seton Heart Institute

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

Patient/Parent Signature _____ Date _____

Print Name _____ Birth Date of Patient _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

The following names listed are those that I give Seton Family of Doctors the authorization to give health information:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

NAME: _____ **DOB:** _____ **AGE:** _____ **SEX:** _____ **DATE:** _____

HEIGHT: _____ **WEIGHT:** _____ **REFERRING DOCTOR:** _____

What is your main reason for seeing a cardiologist?

_____

_____

_____

Do you have previous cardiac problems & how were they treated (including angioplasty or heart surgery)?

_____

_____

Previous heart tests: Stress Test: _____ Echocardiogram: _____ Holter Monitor: _____ Cardiac Catheterization: _____

Have you had any of the following:

High blood pressure Y/N ____ If yes, how long? _____ Years treated? _____ Which meds? _____
Diabetes Y/N ____ If yes, how long? _____ Years treated? _____ Which meds? _____
High cholesterol Y/N ____ If yes, how long? _____ Years treated? _____ Which meds? _____

	Yes/No	When?		Yes/No	When?
Heart Attack	____/	_____	Heart Murmur	____/	_____
Chest Pain (Angina)	____/	_____	Mitral Valve Prolapse or leak	____/	_____
Shortness of breath (exertional)	____/	_____	Rheumatic Fever Heart	____/	_____
Cough/Recent respiratory infection	____/	_____	Valve Infection Mini-	____/	_____
Chest injury/trauma	____/	_____	stroke or stroke	____/	_____
Congestive Heart Failure	____/	_____	Claudication (leg pain)	____/	_____
Leg swelling (edema)	____/	_____	Deep vein thrombosis	____/	_____
Shortness of breath at rest/night	____/	_____	Bleeding problems/anemia	____/	_____
Need for extra pillows to sleep	____/	_____	Asthma/chronic bronchitis	____/	_____
Heart rhythm problems	____/	_____	Ulcers or reflux	____/	_____
Palpitations	____/	_____	Abdominal pain	____/	_____
Dizziness	____/	_____	Nausea/vomiting/diarrhea	____/	_____
Fainting	____/	_____	Kidney problems	____/	_____
Thyroid disease	____/	_____	Liver problems	____/	_____

Any additional past illnesses: _____

Past surgery: _____

Allergies to medications: _____ Allergy to iodine/contrast dye? _____

Medications:

Name	Dose	Times per day

Personal History:

Occupation: _____
Exercise Frequency: _____
Type of diet: _____
Alcohol (drinks/day) _____ Caffeine (drinks/day) _____
Smoking _____ If yes, packs/day _____ Years _____
If past, year stopped _____ Packs/day _____ Years _____
Illicit drug use: Y/N _____
(Women only) Post menopause? _____ Year _____

Family History:

Heart Attack _____ Stroke _____
Hypertension _____ Diabetes _____

Mother living? Y/N _____
If yes, any present illness _____
If no, age of death _____ died of _____
Father living? Y/N _____
If yes, any present illness _____
If no, age of death _____ died of _____

Siblings? Y/N _____ Age _____ Health _____
Age _____ Health _____
Age _____ Health _____
Age _____ Health _____
Age _____ Health _____
Age _____ Health _____
Any deceased? Y/N ____ Age _____ Health _____
Age _____ Health _____

Signature of person submitting information _____

Relationship to patient (if applicable) _____

REV0114

Consent to Treat and Health Care Agreement

Seton Heart Institute

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed by my physician or his/her designee. I understand that Seton Heart Institute includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

I understand that this Consent to treat will be valid for each visit I make to the Seton Heart Institute until revoked by me in writing.

2. Consent to Release Information

I acknowledge that Seton Heart Institute may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Seton's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Seton Heart Institute.

I acknowledge and consent to allow Seton Heart Institute to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Seton Heart Institute all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Seton Heart Institute are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorney's fees and collection expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Seton Heart Institute on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Seton Heart Institute or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payor for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Seton Healthcare Family will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

8. Research Authorization

I authorize the physicians and staff of this office to review my medical records to determine whether I qualify for a potential research study.

9. Notice of Privacy Practice

I acknowledge receipt of the “Notice of Privacy Practices” from Seton Heart Institute.

Patient Printed Name	Patient Date of Birth
Patient/Responsible Party Signature	Date
Witness	Date