Patient Information Form

TEXOMA CARDIOVASCULAR SURGEONS

Name:_____ Home Phone:_____ Cell Phone: _____

Address:_____City:_____ St:_____Zip:_____

Social Security Number:_____-___-_____ DOB:_____ Sex: ☐ M ☐ F

☐ Single ☐ Married-first name_____ ☐ Long Term Partner name_____

☐ Divorced ☐ Widowed ☐ Separated

Employer:_____ Occupation:_____ Employer Phone:_____

Nearest Relative NOT living with you_____ Phone:_____

Nearest Friend NOT living with you _____ Phone:_____

Whom may we contact in case of emergency?_____ Phone: _____

Who is the Person responsible for charges that may incur (other than spouse) ?_____

Do you currently have a pharmacy you use?_____Who?_____ Phone:_____

PLEASE BRING ALL INSURANCE CARDS AND PICTURE ID TO APPOINTMENT
Insurance Information: (You MUST complete the following *in addition* to us copying the cards)

Primary Policy:_____ ID#_____ Group#_____

Type of Plan: HMO ☐ PPO ☐ POS ☐ Other_____ Referral needed? _____

Primary Policy Holder's Name (if other than patient) _____ DOB: _____

Social Security Number:_____-___-_____ Employer:_____Employer Phone:_____

Secondary Policy:_____ ID#_____ Group#_____

Type of Plan: HMO ☐ PPO ☐ POS ☐ Other_____ Referral needed? _____

Primary Policy Holder's Name (if other than patient) _____ DOB: _____

Social Security Number:_____-___-_____ Employer:_____Employer Phone:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this and subsequent sheets and have completed the answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient's Signature or Parent (if patient is a minor) : _____ **Date:** _____

Patient History Questionnaire

TEXOMA CARDIOVASCULAR SURGEONS

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 Problems			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 dates: _____

_____

_____

B. Family History (please list any medical problems in your relatives)

Father: _____ Mother: _____ Siblings: _____
Others: _____

C. Social History (please check all that apply)

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

Patient History Questionnaire
Continued

TEXOMA CARDIOVASCULAR SURGEONS

IV. Review of System (ROS) (please check all that apply)

Constitutional:

	YES	NO
General Good Health		
Recent Weight Change		
Night Sweats, Fevers		
Fatigue		

Ear/Nose/Mouth/Throat:

	YES	NO
Hearing Loss or Ringing		
Sinus Problems		
Nose Bleeds		
Sore throat		

Eyes:

	YES	NO
Wear Corrective Lenses		
Blurred/Double Vision		
Eye Disease/Injury		
Glaucoma		

Cardiovascular:

	YES	NO
Chest Pain		
Palpitations		
Swelling Hands/Feet		

Respiratory:

	YES	NO
Shortness of Breath		
Cough		
Wheezing/Asthma		
Coughing up Blood		

Gastrointestinal:

	YES	NO
Nausea/Vomiting		
Abdominal Pain		
Rectal Bleeding		
Bowel Problems		

Musculoskeletal:

	YES	NO
Muscle Pains/Cramps		
Stiffness/Swelling Joints		
Joint Pain		
Trouble Walking		

Neurological:

	YES	NO
Frequent Headaches		
Paralysis/Tremors		
Convulsions/Seizures		
Numbness/Tingling		

Integumentary (skin/breast):

	YES	NO
Change in Hair/Nails		
Rashes/Itching		
Breast Lump(s)		
Breast Pain/Discharge		

Endocrine:

	YES	NO
Excessive Thirst/Urination		
Thyroid Disease		
Hormone Problems		

Hematological/Lymphatic:

	YES	NO
Bruises Easily		
Slow to Heal		
Enlarged Glands		

Psychiatric:

	YES	NO
Insomnia		
Confusion/Memory Loss		
Depression		

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed:_____ Date:_____

Physician Statement: I have reviewed the questionnaire with the patient.

Signed:_____ Date:_____

Authorization

For Use and Disclosure of Protected Health Information

TEXOMA CARDIOVASCULAR SURGEONS

Patient Name: _____

TEXOMA CARDIOVASCULAR SURGEONS, LLP has been authorized to use and/or disclose the following protected health information (PHI) on the above noted 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 conditioned 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:_____

Consent

For Use and Disclosure of Information

TEXOMA CARDIOVASCULAR SURGEONS

I have reviewed the "Notice of Privacy Practices of TEXOMA CARDIOVASCULAR SURGEONS, LLP" and have had all questions answered by this office.

I also consent to the use or disclosure of my protected health information for the following purposes:

• TREATMENT

It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.

• PAYMENT

Necessary information will be shared with appropriate payer sources and their representative for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for your billing personnel including but not limited to employees, case manager, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.

• HEALTHCARE OPERATIONS

Necessary information will be shared for the continuing operations of this office. Some examples included, but are not limited to: peer review, accreditation, credentialing processes, and compliance with all federal and state laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

Patient Signature or Representative:_____Date:_____

Printed name of Patient or Representative:_____Relationship:_____

Privacy Notice

TEXOMA CARDIOVASCULAR SURGEONS

PATIENT RIGHTS:

ACCESS OF CARE

• You have the right to access treatments that are available or medically indicated regardless of race, creed, sex, or national origin.

NOTICE OF RIGHTS

• You or your representatives have a right to be informed of your rights before care is started or discontinued whenever possible.
• You have a right to prompt resolution of grievances.
• Patients and family members have the opportunity to inform the Office Administrator of complaints concerning quality of care. You may contact her at 903.416.4595.

EXERCISE OF RIGHTS

• You have the right to participate in the development and implementation of your plan of care.
• You or your representatives (as allowed under State law) have the right to make informed decisions regarding your care. Your rights include being informed of your health status and prognosis, being involved in care planning and treatment, including pain management, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

PRIVACY AND SAFETY

• You have the right to personal privacy.
• You have the right to receive care in a safe setting.
• You have the right to be free from all forms of abuse or harass - ment.

CONFIDENTIALITY OF PATIENT RECORDS

• You have the right to the confidentiality of your medical records.
• You have the right to access information contained in your records within a reasonable time frame.

COMMUNICATIONS

• When communication restrictions are medically necessary, you have the right to have these restrictions fully explained.
• You have the right to an interpreter if a language barrier or sensory impairment exists.

PATIENT RESPONSIBILITIES:

PROVISION OF INFORMATION

• You have a responsibility to provide accurate and complete information related to your health; to report that you understand treatment plan and what is expected of you.

COMPLIANCE WITH INSTRUCTIONS

• You are responsible for following the treatment plan and instructions of health care providers.
• You are responsible for keeping appointments or for notifying the appropriate person(s) if your are unable to keep the appointment.

REFUSAL OF TREATMENT

• You are responsible for you actions if you refuse treatment or do not follow instructions.

RESPECT AND CONSIDERATION

• You are responsible for being considerate of the rights of others, for assisting in the control of noise, smoking and the number of persons accompanying you.
• You are responsible for being respectful of the property of other persons and of the office.