Nasser Cardiology, P.A. 3115 College Park Dr Suite 106, The Woodlands, TX 77384
Phone (936)321-2366 Fax (936)266-0469

PATIENT'S NAME: _____ DOB: _____/_____/_____

ADDRESS: _____CITY: _____ STATE: _____ZIP: _____

PRIMARY PHONE: (_____) _____-_____ SECONDARY: (_____) _____-_____

SSN: _____-_____-_____

OCCUPATION: _____

PATIENT EMPLOYER: _____ PHONE: (_____) _____-_____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

SPOUSE'S NAME: _____ PHONE: (_____) _____-_____

SPOUSE'S DOB: ____/____/_____EMPLOYER: _____ PHONE: (_____) _____-_____

REFERRING PHYSICIAN: _____ PHONE: (_____) _____-_____

PRIMARY CARE PHYSICIAN: _____ PHONE: (_____) _____-_____

PRIMARY INSURANCE: _____ PHONE: (_____) _____-_____

POLICY HOLDER: _____ ID #: _____ GROUP #: _____

SECONDARY INSURANCE: _____ PHONE: (_____) _____-_____

POLICY HOLDER: _____ ID #: _____ GROUP #: _____

EMERGENCY CONTACT: _____RELATION TO PATIENT:_____

PHONE: (_____) _____-_____

EMAIL: _____ @ _____.COM (NEEDED FOR PATIENT PORTAL SET UP)

LANGUAGE: _____ RACE: _____ ETHNICITY: _____

PHARMACY NAME, STREET CROSSING, PHONE #:_____

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT, THE PATIENT IS RESPONSIBLE FOR PAYMENT OF DOCTOR'S FEES WITHIN 30 DAYS REGARDLESS OF INSURANCE COVERAGE OR STATUS OF INSURANCE CLAIMS. EXTENTIONS OR CREDIT BEYOND 30 DAYS MUST BE APPPROVED BY THE BUSINESS OFFICE. CLAIMS WILL BE FILED TO YOUR INSURANCE OMPANY AS A COURTESY TO YOU.

I HEREBY AUTHORIZE NASSER CARDIOLOGY P.A. TO FURNISH INFORMATION TO MY INSURANCE CARRIER(S) CONCERNING MY ILLNESS AND/OR TREATMENT PLANS. I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

SIGNATURE: _____ DATE: _____

REASON FOR YOUR VISIT:

A. CHEST PAIN
B. ABNORMAL EKG
C. SWELLING
D. VARICOSE VEINS
E. OTHER: _____

**ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?**

## Please circle:

Headache
Lightheadedness
Fatigue
Weight Gain
Weight Loss
Cough without cold or allergies
Shortness of Breath
Chest pain
Chest pain at rest
Chest pain with exertion
Claudication
Difficulty laying flat
Dizziness
Dyspnea with exertion
Fluid accumulation
Irregular Heart beat
Shortness of breath while laying flat
Palpitations
Weakness
Blood in stool
Heartburn
Rectal Bleeding
Difficulty Urinating
Frequent Urination
Leg Cramps
Muscle Aches
Decreased sensation in arms or legs
Pain or cramping in legs
Ulceration of legs or feet
Blistering of skin
Restless leg syndrome
Discoloration
Balance Difficulty
Difficulty speaking
Fainting
Memory Loss
Loss of vision
Tremor

1. OTHER ILLNESSES
   A. ENLARGED HEART YES NO
   B. HYPERTENTION (HIGH BLOOD PRESSURE) YES NO
   C. DIABETES YES NO
   D. ABNORMAL LIPIDS (HIGH CHOLESTEROL) YES NO
   E. TACHYCARDIA YES NO
   F. KIDNEY PROBLEMS YES NO
   G. HISTORY OF STROKE YES NO
   H. HISTORY OF HEART ATTACK YES NO
   I. OTHER: _____
2. PREVIOUS DIAGNOSTIC TESTING: DATE: WHERE?
   A. EKG (ECG) _____
   B. EXERCISE STRESS TEST (TREADMILL) _____
   C. ECHOCARDIOGRAM _____
   D. CAROTID DOPPLER _____
   E. NUCLEAR STRESS TEST _____
   F. CATHERIZATION _____

3. **ALLERGIES TO MEDICATIONS**/FOOD: _____

4. LIST ANY SURGERIES THAT YOU HAVE HAD:

| DATE | SURGERY |
|---|---|
| | |
| | |
| | |
| | |

10. LIST ANY HOSPITALIZATIONS THAT YOU HAVE HAD:

| DATE | REASON |
|---|---|
| | |
| | |
| | |

11. SOCIAL HISTORY

A. DO YOU SMOKE YES NO
   I. IF YES, WHEN DID YOU START? _____
   II. HOW MANY CIGS/PACKS PER DAY? _____
B. IF YOU DO NOT PRESENTLY SMOKE, HAVE YOU IN THE PAST? YES NO
   I. IF YES, WHAT YEAR DID YOU QUIT? _____
   II. HOW HANY CIGS/PACKS PER DAY? _____
   III. WHEN DID YOU START? _____
C. DO YOU DRINK ALCOHOL? YES NO
D. DO YOU DRINK CAFFEINE? (COFFEE, TEA, SODA, ENERGY DRINKS) YES NO
   I. IF YES, WHAT DO YOU DRINK? _____
   II. HOW MANY TOTAL PER DAY? _____

12. FAMILY HEALTH

| RELATION | GENDER (M/F) | AGE (ALIVE/ DECEASED) | IF DECEASED, CAUSE OF DEATH | HISTORY (STROKE, HEART ATTACK, HIGH BLOOD PRESSURE, DIABETES, HYPERLIPIDEMIA, ETC.) |
|---|---|---|---|---|
| FATHER | M | | | |
| MOTHER | F | | | |
| SIBLINGS | | | | |
| | | | | |
| | | | | |
| | | | | |
| CHILDREN | | | | |
| | | | | |
| | | | | |
| | | | | |

14. PHARMACY NAME, STREET CROSSING, & PHONE NO. _____

15. MEDICATION LIST

IN AN EFFORT TO IMPROVE THE ACCURACY OF YOUR CHART DATA, PLEASE LIST ALLMEDICATIONS THAT YOU ARE TAKING ALONG WITH THE STRENGTH (Mg, grams, IU, mcg, etc.) AND THE EXACT DIRECTIONS (how many, taken how many times a day, etc.)

| NAME OF MEDICATION | STRENGTH | DIRECTIONS |
|---|---|---|
| | | |
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## Authorization for Disclosure of Confidential Information

**Patient Name:** _____

**Date of Birth:** _____ **SSN:** _____

**Address:** _____

**I hereby authorize Nasser Cardiology, P.A. to:**

- **Release to**
- **Receive from**

**Name of Person or Facility:** _____

**Street Address:** _____

**City, State, Zip** _____ **Phone:** _____

**Fax:** _____

- **History and Physical**
- **Lab Results**
- **Cath Reports**
- **Radiology Reports**
- **Nuclear Stress Test**
- **Echo Doppler**
- **EKG**

**PATIENT SIGNATURE:** _____

**DATE:** _____

- **ALL RECORDS**

**Due to the new laws enacted by Congress, we are required to have a signed consent prior to receiving treatment.**

_____ Do you consent to a medical examination and any procedures or tests deemed necessary by Dr. Nasser while you are in our office?

_____ Do you wish Dr. Nasser to release medical information to any specialist that we refer you to?

_____ Do you consent to the staff releasing information about appointments and/or test results to someone on your list?

_____ Do you consent to the staff leaving messages on an answering machine or voicemail system regarding appointments and/or test results?

_____ Do you consent our office mailing bills to your home?

**Please list the names of the person or persons to whom we can discuss your medical information with.**

**Name** **Relationship**

_____

_____

_____

Signature: _____

I,_____ DO NOT give permission to Nasser Cardiology, P.A. or employees to release my medical information to anyone other than myself.

Signature:_____
Print Name:_____ Date: _____

**PATIENT HIPAA CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Act of 1996 (HIPAA)/ I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare Providers involved in my treatment);
- Obtaining payment from third party payers (ex my insurance company);
- The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of you Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I May contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time.

However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of _____, 20_____.

Print Patient name: _____

Signature: _____

Relationship to patient: _____

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I, _____, hereby acknowledge receipt of Nasser Cardiology, P.A., Notice of privacy practices. The Notice of Privacy provides detailed information about how Nasser Cardiology, P.A., may use and disclose my confidential information.**

**I understand that Nasser Cardiology, P.A., reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.**

_____

**Signature**

_____

**Date**

**If you are not the patient, please specify your relationship to the patient:**

_____

**Relationship to Patient**

## BENEFIT INFORMATION AGREEMENT & WAIVER

This information is being provided to help you better understand the process of receiving benefits. We are providing an estimate of your benefits, not an exact quote of what you will owe.

- **We can only ESTIMATE your benefits, as your insurance company applies a disclaimer when quoting benefits "actual benefits will not be considered until a claim is filed."**
- **We share information we obtain from your insurance company with you and explain these to the best of our ability.**
- **If you still do not understand how your benefits are administered, it is YOUR responsibility to contact your insurance directly.**

***Please initial below that you have read and understand this policy.***

_____ When making an appointment, it is your responsibility to confirm with your insurance company that Dr. George Nasser is currently under contract with your plan. If your plan requires a referral and you or your primary care provider do not provide one by the scheduled appointment time, please be prepared to pay for your visit in full or reschedule.

_____ All patient financial responsibility is due at the time services are rendered. Any balances determined by your insurance company will be due at each visit. Please call our office prior to each visit if you need to know in advance how much you will owe.

_____Any balances accrued after the insurance has responded to any claims are required to be paid 30 days after receiving a statement. If you have a past due balance at the time of service for an appointment or testing, you will be responsible for the balance during your visit.

_____ I understand that Nasser Cardiology, P.A. does not accept Medicaid/Amerigroup as primary OR secondary insurance coverage. I further understand that if I schedule an appointment and do not disclose that I am active with either of these plans OR I apply and receive Medicaid/Amerigroup benefits while under the care of Nasser Cardiology, P.A., I HEREBY AGREE TO PAY for any and all services I receive.

I have read, understand and have had an opportunity to ask questions regarding the information on this page and have a received a copy for my records.

PLEASE READ THIS ENTIRE FORM PRIOR TO SIGNING OR INITIALING

Patient Signature: _____ Date: _____

Patient Printed Name: _____

# OFFICE POLICIES

**Welcome and thank you for choosing Nasser Cardiology, P.A. for your health care needs. We look forward to serving you and strive to provide you with the best quality of care. Please carefully review the following valuable information as it is intended to serve as your guide to a smooth and productive visit.**

**LATE ARRIVALS: We do our best to keep the schedule. When a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.**

**CHECK IN: Your time is very important to you and us. The first step in keeping your appointment on time is being prepared. This includes filling out all the required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Forms. This will avoid delays in creating your chart and account at your visit. Please arrive at least 20-30 minutes prior to your scheduled time so that all the paperwork may be completed PRIOR to seeing the physician. Although we verify your benefits before your initial appointment, you must present your current insurance card along with a valid picture ID in order to verify your identity. This will ensure that all information is entered accurately and wil prevent errors in filing claims. Without the insurance card, we will be unable to file with your insurance and you will be responsible for the days charges. On EACH follow-up visit you will be asked to verify demographics and insurance information so that our records remain up to date.**

**RETURN CHECK FEE: There will be a return check fee of $35.00 posted to your account for all checks returned due to non-sufficient funds or closed accounts.**

**MEDICATION HISTORY: You are required to bring an UPDATED medication list EVERY follow up visit, in which we will go over with you during the visit to ensure our records remain up to date.**

**NO SHOWS AND LATE CANCELLATIONS: We require a 24 hour advance notice if you must cancel your appointment. For your convenience, we offer appointment reminder calls 24-48 hours prior to your appointment which will allow you to cancel or reschedule at that time. If you NO-SHOW and appointment you may be subject to a $25.00 fee.**

**Patient Name:**_____ **Date:**_____

**Signature:**_____