THE TEXAS HEART INSTITUTE®
CENTER FOR CARDIOVASCULAR CARE
6624 Fannin, Suite 2600 • Houston, Texas 77030 • (713) 790-9401

Welcome to The Texas Heart Institute Center for Cardiovascular Care

We know that you have many choices when it comes to your cardiovascular care, and we thank you for choosing The Texas Heart Institute Center for Cardiovascular Care. Our professional staff is dedicated to high-quality individualized care for each of our patients, using a patient-focused approach that is designed to promote your long-term health and wellbeing. The following information will assist you in making your visit with us as convenient and pleasant as possible.

Appointments:

We strive to see our patients promptly at the scheduled appointment time. Due to our unique practice setting, we are able to provide multiple in-office tests throughout the day. Please assist us in keeping our schedule running on time by following these simple steps.

- There may be paperwork to fill out before your appointment regardless of whether you are a new patient or an established patient.
- When calling to make a routine appointment, it may be necessary to leave a message for the scheduler. Urgent, non-life threatening matters may be handled more appropriately by dialing the main number and pressing option 4 for the nurses (you still may have to leave message). Clearly state your name, date of birth and a call back number.
- If you are unable to keep your scheduled appointment, please notify our office at least 24 hours in advance.
- Please arrive at the time given to you by the scheduler.
- If you arrive late for your appointment, your scheduled testing may be rescheduled for another day or moved to a later time on the same day.

Please bring the following items with you to every appointment:

- Insurance card(s).
- Photo ID such as driver's license or state-issued ID.
- Payment via MasterCard, Visa, American Express, Discover or personal check.
- Complete list of medications you are currently taking, including any over-the-counter medications, vitamins or supplements. Please remember to include the dose and how each medication is taken (i.e. daily, twice daily, etc).
- The phone number, fax number and address for your local and/or mail order pharmacy.

Financial Policy:

- Financial responsibility is yours regardless of insurance coverage. Health insurance coverage is a contract between you and your insurance carrier.
- It is your responsibility to select a participating provider in your insurance network, and to ensure proper authorization from your insurance carrier.
- While we do our best to verify your coverage and benefits prior to your visit, please contact your carrier for an explanation of your coverage and benefits. It is ultimately your responsibility to make sure the services you receive are covered, and to determine your financial obligation.
- You will be expected to pay any outstanding balances, deductibles and/or co-pay at the time of your visit. If this is not possible, you should contact the Billing Office at (713) 790-9401 option 5 prior to your appointment to make payment arrangements.
- It is your responsibility to contact our office with any changes to your insurance, home address or phone number.
- All billing inquiries should be directed to your Billing Office at (713) 790-9401 option 5.

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Forms:

- Patients often ask us to help them complete specific forms for their job or insurance company.
- There will be a $30 fee to have the forms completed and please allow 7-10 business days to process the forms.

Refills:

- The Texas Heart Institute Center for Cardiovascular Care tries to process all medication refill request electronically. Please contact your pharmacy to send the request, which will speed up our response.
- Refills require 48 hours processing time. Please plan accordingly for weekends or holidays.
- If you participate in a mail order pharmacy service, please make sure you have created an account with the pharmacy and we will electronically fill your prescription or send it via fax.

Referrals / Authorizations:

- Please allow 72 hours for referrals to a specialist or authorizations for certain medical tests or procedures.
- Provide all of the information requested in order to obtain the referral or authorization. Providing incomplete information will delay the process.
- If your insurance plan requires a referral from your primary care physician, please bring a copy of the referral with you or fax it in advance to (713) 600-9332.

Lab and Test Results:

- Remember to review your contact information and HIPAA form with the front desk to ensure the contact information we have on file is accurate.
- If a particular test result the physician ordered was unavailable during the visit, please allow 3 business days for our nurse or medical assistant to contact you with those results.
- If you have not heard from our office after 5 business days, please call the office.

Phone / Email Messages:

- Your phone and/or email messages will be returned within 24 hours.
- Messages left after 3:00pm will be returned the next business day.
- Messages left after 3:00pm on Friday will be returned on Monday.
- When leaving a message or sending an email, please include your name, the patient's name (if different), the patient's date of birth, the reason for your call/email and your call back phone number.
- If your call/email is regarding a medical emergency, do not leave a message or send an email. Dial 911 immediately.

Medical Records:

- Requests for a copy of your medical records must be made in writing, and accompanied by a completed and signed authorization form.
- There may be a charge for a copy of your medical record.
- If you need a copy of medical records to provide to another physician, please indicate the physician and contact information on the authorization form and we will send your records directly to the physician.

For directions to our office, please see the next page.

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Directions to Our Office

From Cleveland / Kingwood (Hwy 59) – Take Highway 59 South to Houston. Drive through downtown Houston and exit Hwy 288 South towards the Medical Center. From Hwy 288 South, exit Holcombe Blvd and take a right onto Holcombe. At Fannin Street, take another right. Our building has two twin peaks and is located on the left side of Fannin Street. Enter the Visitor Parking or the Valet Parking entrance for the St. Luke's Medical Tower at 6624 Fannin Street. Our office is located on the 26th floor in Suite 2600.

From Conroe / The Woodlands (I-45) – Take Interstate 45 South to Houston. Drive through downtown Houston and exit Hwy 288 South towards the Medical Center. From Hwy 288 South, exit Holcombe Blvd and take a right onto Holcombe. At Fannin Street, take another right. Our building has two twin peaks and is located on the left side of Fannin Street. Enter the Visitor Parking or the Valet Parking entrance for the St. Luke's Medical Tower at 6624 Fannin Street. Our office is located on the 26th floor in Suite 2600.

From Victoria / Sugarland (Hwy 59) – Take Highway 59 North to Houston. Drive towards downtown Houston and exit Hwy 288 South towards the Medical Center. From Hwy 288 South, exit Holcombe Blvd and take a right onto Holcombe. At Fannin Street, take another right. Our building has two twin peaks and is located on the left side of Fannin Street. Enter the Visitor Parking or the Valet Parking entrance for the St. Luke's Medical Tower at 6624 Fannin Street. Our office is located on the 26th floor in Suite 2600.

From Galveston (I-45) – Take Interstate 45 North to Houston. Exit Loop 610 South (exit to the left). Take Loop 610 and exit Hwy 288 North to Houston. From Hwy 288 North, exit Yellowstone. Drive on the Hwy 288 North frontage road until you reach Holcombe Blvd. Take a left over the Interstate onto Holcombe. At Fannin Street, take another right. Our building has two twin peaks and is located on the left side of Fannin Street. Enter the Visitor Parking or the Valet Parking entrance for the St. Luke's Medical Tower at 6624 Fannin Street. Our office is located on the 26th floor in Suite 2600.

From Pearland (Hwy 288) – Take Hwy 288 North to Houston. From Hwy 288 North, exit Yellowstone. Drive on the Hwy 288 North frontage road until you reach Holcombe Blvd. Take a left over the Interstate onto Holcombe. At Fannin Street, take another right. Our building has two twin peaks and is located on the left side of Fannin Street. Enter the Visitor Parking or the Valet Parking entrance for the St. Luke's Medical Tower at 6624 Fannin Street. Our office is located on the 26th floor in Suite 2600.

From San Antonio / Katy (I-10) – Take Interstate 10 East to Houston. Exit Loop 610 West and drive past the Galleria and continue to drive on Loop 610 South. Take Loop 610 South and take the Fannin Street exit. Turn left and drive under the overpass on Fannin Street north towards the Medical Center. Our building has two twin peaks and is located on the left side of Fannin Street past Holcombe Blvd. Enter the Visitor Parking or the Valet Parking entrance for the St. Luke's Medical Tower at 6624 Fannin Street. Our office is located on the 26th floor in Suite 2600.

From Beaumont / Channelview (I-10) – Take Interstate 10 West to Houston. Exit Highway 59 South. Drive through downtown Houston and exit Hwy 288 South towards the Medical Center. From Hwy 288 South, exit Holcombe Blvd and take a right onto Holcombe. At Fannin Street, take another right. Our building has two twin peaks and is located on the left side of Fannin Street. Enter the Visitor Parking or the Valet Parking entrance for the St. Luke's Medical Tower at 6624 Fannin Street. Our office is located on the 26th floor in Suite 2600.

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MEDICAL HISTORY / MEDICATION SHEET

Patient Name: ______________________ DOB: ______________ Date of Visit: ______________

Pharmacy Information:

Check which pharmacy refills should be sent to:

Local Pharmacy Name: ______________________________ Phone #: ______________

Mail Order Pharmacy Name: ______________________________

Primary Care Physician Name & Phone #: ______________________________

Please list all medications, vitamins, herbal supplements and any other over-the-counter medication you are taking with the strength and directions of each. (PLEASE LIST EVERY PILL YOU TAKE)

MEDICATIONS / VITAMINS	STRENGTH (Ex. 50 mg)	DIRECTIONS (Times a day)	MEDICATIONS / VITAMINS	STRENGTH (Ex. 50 mg)	DIRECTIONS (Times a day)

Allergies: ______________________________

Past Medical History:

Please summarize your medical history. Indicate if you have had diabetes, hypertension, high cholesterol, cancer, thyroid, pulmonary, neurologic disease, kidney disease, gastroenterologic disease, etc. Note the approximate onset in months/years.

Family History:

Please summarize illnesses that your family members (parents, brothers/sisters, etc.) have or have had. Include age at time of onset of illness and age at time of death (ex. Heart attack at 56 and died of heart failure at 60. He also had diabetes and high blood pressure. He was a heavy smoker)

Mother: ______________________________

Father: ______________________________

Brothers/Sisters: ______________________________

Other:

Social History:

Do you or have you ever smoked or used any other tobacco products? ☐ Yes: ☐ No How much per day/week? __________

Do you consume alcohol? ☐ Yes: ☐ No How much per day/week? __________

Past Surgical History: Please indicate type of surgery, date and why it was done (ex. Hysterectomy at 45 for fibroids)

How did you hear about our practice? ______________________________

Primary Care Physician (address and phone number): ______________________________

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Information about you and your health is personal, and we are committed to protecting your privacy. This notice tells you about our privacy practices, the ways in which we may use and share your health information, and how you can get access to your health information. This notice also describes your rights and our responsibilities regarding the use and disclosure of health information.

1. Our Uses and Disclosures

We typically use and share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. Examples: we will share health information about you with a hospital where you are scheduled for a procedure; we will share your health information with a physician to whom you have been referred for further treatment.

Bill for our services: We can use and share your health information to bill and receive payment from health plans and other entities. Example: we will share your health information with your health insurance plan so it will pay for services we provide to you.

Run our organization: We can use and share your health information to run our operations, train medical students, improve your care and contact you when necessary. Examples: we may disclose your health information to medical school students that see patients at our office; we may use a sign-in sheet at the registration desk where you will be asked to write your name and your physician's name; we may call you by name in the waiting room when your physician is ready to see you.

Communicate regarding treatment alternatives or appointment reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

How else can we use or share your health information? We are allowed or required to share your health information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information, see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues: We can share information about you for certain situations, such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Food and Drug Administration (FDA): We may share health information with the FDA relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

2. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Please contact the office directly where you receive care.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements. We may charge a reasonable, cost-based fee.
- If you ask that we send a copy of your medical record or other health information to someone other than you, we may ask you to complete a written authorization. You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization, send written notice to:

  Practice Administrator
  The Texas Heart Institute
  Center for Cardiovascular Care
  6624 Fannin, Suite 2780
  Houston, TX 77030

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. You may also view a copy of this notice on our website.

Ask us to limit what we use or share:

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

File a complaint if you feel your privacy rights have been violated.

- You can complain if you feel we have violated your privacy rights by contacting us directly using the information at the top of this notice.
- You can also contact our Privacy Officer:

Privacy Officer
The Texas Heart Institute
MC 3-116
PO Box 20345
Houston, TX 77225
Phone: 832-355-3043
Email: privacy@texasheart.org

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

3. Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

4. Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

5. Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date: May 10, 2021

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ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you received our Notice of Privacy Practices.

Print Name: ______________________________________

Signature: ____

Date: ____

Date of Birth: _____________________________________

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PATIENT DEMOGRAPHICS SHEET

(PLEASE PRINT)

___ / ___ / ___
Appointment Date

Last Name: ______________ First Name: ______________ MI: ______

Date of Birth: ______________ Sex: ☐ Male ☐ Female

Address: ______________________________

______________ (City) ______________ (State) ______________ (Zip Code)

Phone #: ______________ (Home) ______________ (Work) ______________ (Cell)

Email Address: ______________ Communication Preference: ☐ Phone ☐ Text ☐ Email

INSURANCE INFORMATION

(Subscriber Information)

Primary Insurance: ______________

Insurance Phone No: ______________

ID #: ______________

Group #: ______________

Subscriber Name: ______________

Insured Date of Birth: ______________

Sex: ☐ Male ☐ Female

Secondary Insurance: ______________

Insurance Phone No: ______________

ID #: ______________

Group #: ______________

Subscriber Name: ______________

Insured Date of Birth: ______________

Sex: ☐ Male ☐ Female

EMERGENCY CONTACT

(Name of friend or relative not living with you)

Last Name: ______________ First Name: ______________ MI: ______

Phone #: ______________ (Home) ______________ (Cell) Relationship: ______________

PHARMACY INFORMATION

Check which pharmacy refills should be sent to:

Local Pharmacy Name: ______________ Phone #: ______________

Mail Order Pharmacy Name: ______________

Primary Care Physician Name & Phone #: ______________

How did you hear about our practice? ______________

Referring Name: ______________ Phone #: ______________

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In-Office Testing

For your convenience, we provide multiple in-office testing. A brief synopsis and patient instructions for each test are found below.

1. **Exercise Treadmill Testing (Stress Test)** is performed to evaluate heart rate, heart rhythm and coronary heart disease. The patient is monitored by an electrocardiogram (EKG) while walking on a treadmill. The test takes approximately 30-45 minutes.
   Preparation: We ask that patients wear comfortable shoes and clothing to perform this test. It is preferable that the patient refrains from eating a heavy meal close to the testing time since they will be exercising. It is also preferred that the patient refrains from any caffeinated products 2 hours prior to testing if possible. All regular medications may be taken prior to this test.

2. **Nuclear Stress Testing** is performed to evaluate coronary artery disease. The patient is injected with a radioactive (nuclear) isotope called Sestamibi via an IV placed in the patient's arm or hand. The radioactive isotope is commonly mistaken for a contrast medium or dye-it is NOT a dye. The patient is asked to wait for a period of approximately 10-15 minutes, then the first set of images are obtained. The images take approximately 10 minutes. After these pictures are obtained, the patient performs an exercise treadmill test, or if the patient is unable to perform an exercise treadmill test the patient will be injected with a drug called Adenosine. The Adenosine will be injected through the IV after the first set of nuclear images is obtained. Another dose of radioactive isotope will be given during the stress test via the IV. After the stress test, the patient is encouraged to eat and drink a snack. After this time, the patient has a second set of images obtained in the nuclear room. The second set takes 10 minutes. The nuclear stress test takes approximately 3 hours to complete from the first injection until the second set of images is complete.
   Preparation: We ask that patients wear comfortable shoes and clothing to perform this test. *No caffeine or decaffeinated products 24 hours prior to the test.* This includes coffee, sodas, chocolate and tea. All medications may be taken with a sip of water.
   Patients who are scheduled for morning testing: Patients are not to eat or drink anything after midnight the night before the test.
   Patients who are scheduled for aftemoon testing: Patients are to eat ONLY a small piece of toast, small banana, small bowl of oatmeal with water or juice before 8:00 AM. Nothing may be eaten after 8:00 AM. Diabetic patients should be scheduled for afternoon testing since they are allowed to eat in the early morning.

3. **Echocardiogram,** or echo, is an ultrasound of the heart. It is performed to evaluate the heart valve function, wall motion and thickness, blood flow and chamber sizes. The images are obtained by placing an ultrasound probe on the patient's chest. The 2D echo takes approximately 45 minutes to 1 hour.
   Preparation: The patient may eat prior to the test; however, we ask that the patient refrains from any caffeinated products 2 hours prior to the test if possible. All regular medications may be taken prior to this test.

4. **Peripheral Vascular Tests** are ultrasound tests, or doppler studies, performed to evaluate blood flow in different areas of the body. The measurements are obtained by placing a probe on the specific areas of the body. The doppler studies that we perform include arterial studies of the arms and of the legs, venous studies of the arms and of the legs, carotid artery studies of the neck as well as renal and abdominal studies. The times for each study vary from 1 hour to 2 hours. All regular medications may be taken prior to all peripheral vascular testing.
   Preparation for Carotid, Venous and Leg/ Arm study: The patient may eat prior to testing.
   Preparation for Renal and Abdomen study, follow the instructions below:
   Evening p1ior to study:
   To maximize the results of the study, patients should take a laxative (any brand laxative) at 2:00 PM the day before the study and should eat a light dinner consisting of light broth, jello, etc. Nothing to eat or drink after midnight, however, the patient is able to take regular medications with a small sip of water.
   Morning of study:
   Patient should take their regular medications with a small sip of water. The patient should perform an enema while at home. (They may use the Fleet brand enema.) If the first enema does not produce any results, patient should perform

a second enema. On the way to the office, the patient should chew 2 to 3 Mylicon tablets to reduce any gas in their abdomen.

5. **Electrocardiogram (EKG)** is performed to assess heart rhythm. No preparation. All regular medications may be taken prior to this test.

6. **Chest X-ray(CXR)** is ordered to assess the lungs and size of the heart. No preparation. All regular medications may be taken prior to this test.

7. **Holter Monitor** is worn for 24 hours by patients to monitor their heart rhythm. When the Holter monitor is removed, it takes approximately 1 hour to scan the results. No preparation. All regular medications may be taken prior to this test.

8. **Laboratory tests** are, at times, ordered by the physicians. For some laboratory tests, the patient is asked to have nothing to eat or drink after midnight before the test. All regular medications may be taken prior to this test.

*** The appointment schedulers will contact you with your specific instructions for your office visit. Not all of the above preparations should be followed- only the preparation for your specific test should be followed once your appointment has been confirmed. Please feel free to contact an appointment scheduler with any questions you may have regarding your time and/or preparation instructions. Thank you.

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PATIENT FINANCIAL RESPONSIBILITY CONTRACT

(PLEASE PRINT)

Patient's Name: ______________________________ Date of Birth: ________________ Account: ________________

- Thank you for choosing The Texas Heart Institute Center for Cardiovascular Care as your health care provider. We are committed to providing high quality care and service to our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash (U.S. Dollars), check, credit cards, debit cards and pre-approved insurance, for which we are a contracted provider.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage prior to treatment. Should you fail to provide this information, you will be financially responsible.

- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility.

- If you do not have insurance, you will be expected to pay for all services rendered on the day of your visit.

- If we do not contract with your insurance company, you will be expected to pay for all services rendered on the day of your visit. We will provide you with a statment that you can submit to your insurance company for reimbursement, if applicable.

- Proof of payment method and photo ID are required for all patients. If you have insurance, we will as to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

- Cash (U.S. Dollars), check, credit cards and debit cards are acceptable forms of payment for services. If fees are incurred related to checks returned for non-sufficient funds, you will be expected to pay such fees.

- Your signature below authorizes the release of medical information necessary to file claims with insurance payers. All other requests for medical records must be authorized by myself in writing.

I have read the patient financial responsibilities presented above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

______________________________ ______________________________

Signature of Patient/Responsible Party Date

______________________________ ______________________________

Name of Patient/Responsible Party (please print) Relationship to Patient

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND PRIMARY CARE PHYSICIANS

You have reviewed and signed the Notice of Privacy Practices that describes how we disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

NOTE: You have the right to request a restriction of your protected health information at any time. However, patients may request we communicate their protected health information to spouses, relatives or friends. Examples are communicating appointment times, pre-procedure instructions, relaying test results, relaying medication instructions, communicating physician's orders and other such protected health information to someone besides you. If you request this right, we are required to have a completed authorization on file **prior** to releasing your protected health information. If you wish for someone to have access to your protected health information please complete the authorization below.

The protected health information covered by this authorization includes communicating over the telephone the following: (**Please initial by each protected health information you wish to be disclosed**)

_____ Appointment Times and Instructions   _____ Questions Regarding Current Health Status   _____ Test Results

_____ Physician Orders   _____ Pre-Procedure Instructions   _____ Medication Questions or Changes

I authorize the individuals below access to my protected health information over the telephone. This authorization is effective until such time as you revoke or terminate this authorization.

_______________________________	_______________________________
Name	Relation
_______________________________	_______________________________
Name	Relation

You also have the right to request to receive confidential communications from us by alternative means other than speaking with you over the phone. An example is by answering machine, voice mail, fax machine or email. These means may or may not be secure if others have access to them. If you request this right, we are required to have a completed authorization on file prior to releasing your information.

The protected health information covered by this authorization includes communicating via the follow means and will remain in effect until such time as you revoke or terminate this authorization. (**Please initial by each method you wish our practice to communicate with you**)

_____ Answering Machine at Home   _____ Voice Mail on Cell Phone   _____ Voice Mail at Work   _____ Email

If you would like our office to communicate your protected health information to your primary care physician or referring physician, please indicate their name and address:

Name of Physician: ____

Address of Physician: ____

Signature below is only acknowledgement that you have read and understand the implication of this authorization to release your protected health information to others designated above, to your referring physician and/or communicate by alternative means.

______________________	______________________	____________
(**PRINT NAME**)	(**SIGNATURE**)	(**DATE**)

THE TEXAS HEART INSTITUTE®

CENTER FOR CARDIOVASCULAR CARE

6624 Fannin, Suite 2600 • Houston, Texas 77030 • (713) 790-9401

REVOCATION OF AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The Privacy Laws outline your right to revoke or terminate the authorization to use and disclose protected health information at any time.

This notice revokes the authorization to the use and disclosure of protected health information to the following individuals:

__________________________	__________________________
Name	Relation
__________________________	__________________________
Name	Relation

The original consent was signed on:

____

Date of Original Authorization

EFFECT OF REVOCATION

Protected health information that is collected on or after the date on which this form is received will not be used or disclosed by our practice for any purposes not related to treatment, payment or health care operations as outlined in the signed Notice of Privacy Practices.

The effective date of the revocation of authorization to use or disclose protected health information is ____________________.

Signature below is only acknowledgement that you have read and understand the implication of this authorization to release your protected health information to others designated above, to your referring physician and/or communicate by alternative means.

__________________________	__________________________	______________
(PRINT NAME)	**(SIGNATURE)**	**(DATE)**