Connected Cardiovascular Care Associates
Phone: 214-814-1550
Fax: 214-814-1350
texasC3.com

Patient Name: _____ DOB:_____

Consent to Treat

I hereby authorize employees and agents (including physicians, physician assistants, and nurse practitioners) of this medical office to render routine medical care to me, the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) I hereby authorize employees and agents of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, medical care will not be provided except in a case of emergency.

Financial Responsibility

I hereby authorize payments from Medicare or other insurance companies of medical benefits directly to Connected Cardiovascular Care Associates and/or the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I appoint Connected Cardiovascular Care Associates to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Connected Cardiovascular Care Associates. I further understand that should by account become delinquent, I shall pay the reasonable fees or collection expenses, if any. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier. The duration of this authorization is indefinite and continues until revoked in writing.

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Release of Information
Authorization is hereby granted to release of information contained in my medical record as may be necessary for medical treatment or to process and complete my insurance claims. I understand that this release of information may include information regarding communicable diseases such as, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The duration of this authorization is indefinite and continues until revoked in writing.

Financial Policies
I have read and received a copy of the financial policies for Connected Cardiovascular Care Associates.

Acknowledgement of Receipt of the Notice of Health Information Practices for Connected Cardiovascular Care Associates
The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Connected Cardiovascular Associates and associated physicians are committed to securing the privacy of your health information. We have made available to you a copy of the notice which provides information about how its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Connected Cardiovascular Care Associates' Notice of Health Information Practices.

I have read all of the above and agree to these terms.

_____ _____

Signature of Patient/ Legal Guardian (if patient is a minor) Date

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Financial Policies

Welcome to our practice and thank you for choosing Connected Cardiovascular Care Associates to care for you and/or your loved ones. We are committed to providing you with the highest-quality care and exceptional customer service. Because some of our patients have had questions regarding patient and insurance responsibilities for services rendered, we have developed this financial policy. Our billing office is located in Dallas and can be reached at 972.792.5700 if you need assistance.

INSURANCE:
We participate in most insurance plans. Please bring your up-to-date insurance card with you to each visit. It is your responsibility to make sure that our providers are on your specific plan and in-network for you. If you are insured by a plan we accept, but do not have an up-to-date insurance card, payment in full is required until we can verify your insurance coverage. If you are not insured by a plan we do business with, payment is required in full at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

PROOF OF INSURANCE:
We must obtain a copy of your driver's license and a current valid insurance card to provide proof of insurance. If your health insurance changes, please notify us before your next visit so we can make the appropriate changes to help you maximize your benefits. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES:
All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. We accept cash, check, Visa, MasterCard and Discover.

CLAIM SUBMISSION:
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain

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information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any reason, our office cannot be responsible for that bill. It is your responsibility as the patient to pay the denied amounts in full. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. It is your responsibility to know if our providers are in-network for your insurance plan and what your specific insurance plan's benefits are.

NON-COVERED SERVICES:
Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. As with all non-covered services, you will be expected to pay in full whatever the insurance companies do not reimburse.

NONPAYMENT:
If your account is over 90 days past due, you will receive a letter stating that the balance should be paid in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. Should this occur, you will be notified by certified mail and will have 30 days to find a new physician.

PHONE CALLS:
By providing contact information, I authorize Connected Cardiovascular Care Associates, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

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MISSED APPOINTMENTS:

If you cannot keep your appointment, you will need to reschedule your appointment 24 hours in advance. This will allow us to schedule another patient in that time slot. If any office visit appointment is no-showed, cancelled with less than 24 hours' notice or rescheduled due to late arrival the following charge may be billed to your account depending on the appointment type.

Office visit	$35.00 Fee
Vein procedure	$100.00 fee
Cardiac/vascular testing	$100.00 fee
Nuclear testing	$250.00 fee

This charge is not payable by your insurance company. If multiple appointments are missed and we identify a problem with you keeping appointments, we will not be able to provide care for you at this office.

FORMS:

There is a $25 charge for the completion of FMLA, disability and other forms. Since insurance companies do not cover this service, this charge is your responsibility. Payment is due at the time the forms or requests are dropped off at the clinic.

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

Connected Cardiovascular Care Associates Phone 214-814-1550 / Fax 214-814-1350

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

12740 Hillcrest Rd, Ste 265, Dallas TX 75230

Address (Street, City, State and ZIP)

FROM:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient

CONNECTED CARDIOVASCULAR CARE ASSOCIATES

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ **State:**_____ **Zip Code:** _____ **Email:** _____

Home#: _____ **Cell#:**_____ **Work#:** _____

Preferred Method of for appointment reminders: ☐ Phone ☐ Text ☐ Email

Date of Birth: _____/_____/_____ **Sex:** ☐ Male ☐ Female **SS#:** _____

Race: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic **Preferred Language:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Occupation:**_____

Referred by Family/ Friend/ Doctor: _____

Primary Care Provider_____ **PCP Phone Number**_____

Preferred Pharmacy: _____ **City:** _____ **Phone #:** _____

Intersection: _____

INSURANCE INFORMATION

Primary Insurance:_____ **Policy/ID#** _____

Name of Policy Holder:_____ **DOB:** _____/_____/_____ **Group/Acct #:**_____

Employer: _____ **Employer Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Work #:** _____

Secondary Insurance:_____ **Policy/ID#** _____

Name of Policy Holder:_____ **DOB:** _____/_____/_____ **Group/Acct #:**_____

Employer: _____ **Employer Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Work #:** _____

Signature of Patient or Legal Representative:_____

Printed Name and Relationship: _____ **Today's Date:** _____

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Patient Name: _____ DOB:_____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

I hereby give my permission to Connected Cardiovascular Care Associates to disclose and discuss information related to my medical condition(s) to/with the following persons:

Name: _____ Relationship: _____
Ph#: _____

Name: _____ Relationship: _____
Ph#: _____

Name: _____ Relationship: _____
Ph#: _____

☐ I do not wish to give consent for any person to have access to any information regarding my medical condition(s).

EMERGENCY CONTACT

Name : _____ Relationship: _____
Ph#: _____

This authorization shall remain in effect unless otherwise revoked in writing, I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any records.

Signature of Patient or Legal Representative:

_____ _____
Signature of Patient/ Legal Guardian (if patient is a minor) Date

MEDICAL HISTORY

NAME: _____ _____ _____ **D.O.B.** ____/____/_____
LAST FIRST M.I.

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

ALLERGIES (Include medications, foods, xray dyes) or ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name:_____ Phone #:_____ Fax #: _____

Address:_____ City:_____ State/Zip:_____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ **NONE**

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual cycle: _____

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of_____packs/day for_____years. I quit in_____(year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Have you ever used intravenous drugs? ☐ Yes ☐ No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack	☐	☐	
Diabetes	☐	☐	
Prostate cancer	☐	☐	
Kidney cancer	☐	☐	
Kidney stones	☐	☐	
Other significant disease	☐	☐	

NAME: _____ _____ _____ **D.O.B.** ___/___/_____

Last First M.I

Please circle the complaint(s) or ailment(s) that apply to you. If you are unsure place a question mark (?)

General
- Malaise ☐Yes ☐No
- Chills ☐Yes ☐No
- Fever ☐Yes ☐No
- Weight loss ☐Yes ☐No

Other: _____

Respiratory
- Cough ☐Yes ☐No
- Hemoptysis ☐Yes ☐No
- Shortness of breath with exertion ☐Yes ☐No
- Wheezing ☐Yes ☐No

Other: _____

Cardio (Heart)
- Chest Pain ☐Yes ☐No
- Claudication ☐Yes ☐No
- Difficulty Laying Flat ☐Yes ☐No
- Dizziness ☐Yes ☐No
- Dyspnea on exertion ☐Yes ☐No
- Fluid accumulation, legs Yes ☐No
- High Blood Pressure ☐Yes ☐No
- Irregular heartbeat ☐Yes ☐No
- Orthopnea ☐Yes ☐No
- Palpitations ☐Yes ☐No
- Shortness of breath ☐Yes ☐No
- Swelling in hands/feet ☐Yes ☐No

Other: _____

Gastrointestinal
- Abdominal discomfort ☐Yes ☐No
- Bloody or black stools ☐Yes ☐No
- Change in Bowel habits Yes ☐No
- Decreased appetite ☐Yes ☐No
- Diarrhea ☐Yes ☐No
- Hematemesis ☐Yes ☐No
- Nausea ☐Yes ☐No
- Vomiting ☐Yes ☐No
- Weight loss ☐Yes ☐No

Other: _____

Hematology/ Oncology
- Pallor ☐Yes ☐No
- Easy bruising ☐Yes ☐No
- History of cancer ☐Yes ☐No

Other: _____

Genitourinary
- Incontinence ☐Yes ☐No
- Urinary retention ☐Yes ☐No
- Painful urination ☐Yes ☐No

Other: _____

Musculoskeletal
- Arthritis/Arthralgia ☐Yes ☐No
- Back problems ☐Yes ☐No
- Muscle aches ☐Yes ☐No
- Painful joints ☐Yes ☐No
- Weakness ☐Yes ☐No

Other: _____

Skin
- Change in pigmentation Yes ☐No
- Foot ulcers ☐Yes ☐No
- Rash ☐Yes ☐No

Other: _____

Neurologic
- Balance difficulty ☐Yes ☐No
- Difficulty speaking ☐Yes ☐No
- Dizziness ☐Yes ☐No
- Fainting ☐Yes ☐No
- Gait abnormality ☐Yes ☐No
- Loss of use of extremity ☐Yes ☐No
- Stroke ☐Yes ☐No
- Transient loss of vision ☐Yes ☐No

Other: _____

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AUTHORIZATION TO RETRIEVE MEDICATION RECORDS

I authorize Connected Cardiovascular Care Associates to retrieve my complete medication profile from my insurance, pharmacy, or other third party source. I understand this information will be kept confidential and used only to aid in my ongoing treatment.

I understand this authorization will remain in effect until/unless I revoke it in writing.

_____
Signature of Patient (or Authorized Representative)

_____
Date