MONTGOMERY HEART & WELLNESS

PATIENT INFORMATION

PLEASE FILL OUT ALL SECTIONS COMPLETELY

DATE_____________

Name ____Marital Status ________________
(First) (Middle) (Last)

Social Security # _________ - ______ - _________ Date of Birth _____________________ Male / Female (circle one)

Mailing Address ____________________________________ City ______________ State ______ Zip _________________

Residence Telephone ____________________Cellular _______________________Email _____________________________

INSURANCE INFORMATION

PRIMARY INSURANCE

____
Insurance Co. Name Address, City, State, Zip, Phone Number

___________________________ _____________________ ____________________________
Subscriber's ID # Group # Policyholder's Name

Patient's relationship to policyholder (circle one): Self Spouse Child Other Policyholder's Date of Birth ____________________

SECONDARY INSURANCE

____
Insurance Co. Name Address, City, State, Zip, Phone Number

___________________________ _____________________ ____________________________
Subscriber's ID # Group # Policyholder's Name

Patient's relationship to policyholder (circle one): Self Spouse Child Other Policyholder's Date of Birth ____________________

BILLING INFORMATION

Person responsible for paying bills: Patient Spouse Parent Other ____

Name (If different from above) ____ Date of Birth _________________

Address____

PHARMACY INFORMATION

Name ____________________________________ Phone Number ____

Address ____

EMPLOYMENT INFORMATION

Employer's Name & Address____

Phone Number __________________________ Occupation ____
Was this an accident? Yes / No (Circle one) If Yes indicate: Auto Worker's Comp Other (Circle one)

EMERGENCY CONTACT – REFERRING PHYSICIAN -- PCP

Name: ________________________________ Phone Number _____________________ Relationship ____________________

Referring Physician: ____
Name Phone Number

Primary Care Physician: ____
Name Phone Number

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. Our professional services are rendered to you, not the insurance company; therefore payment for treatment is your responsibility. We have prepared this material to acquaint you with our policy. We encourage you to discuss any questions you have.

FINANCIAL AGREEMENTS

_____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to dependents or myself
Initial ***at the time of service.***

_____ I understand if I fail to pay amounts owed; the clinic has the right to secure an outside collection agency and/or attorney to
Initial collect the unpaid debt and to report the debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney fees.

INSURANCE AUTHORIZATION AND ASSIGNMENT

_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be
Initial made to Houston Cardiac Association for services rendered to my dependents or myself.

_____ I understand I am responsible ***at the time of service*** for paying any required co-payments and/or deductibles. I understand
Initial that I am responsible for any amount not covered by my insurance.

MEDICARE/MEDIGAP

For Medicare Patients Only

____
Medicare Number

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health
Initial Care Finance Administration or its intermediaries or carriers any information needed for this of a related Medicare claim. I permit a copy of the authorization to be use in place of the original, and request payment of Medical insurance benefits either to myself of the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Medigap Authorization Statement

____
Policy Number

_____ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a
Initial copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

NOTICE OF NON-CANCELLATION FEE

If you have an appointment scheduled in our office and you are not able to keep that appointment, you must give at least 24 hour notice of cancellation of your appointment during normal office hours. If you do not call the office 24 hours ahead of time, a non-cancellation fee of $25 will be billed to you.

_____ I understand that I am responsible for a $25 non-cancellation fee if I fail to cancel a scheduled appointment 24 hours in
Initial advance.

We accept cash, checks, and credit cards. There will be a $30 charge on all returned checks.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF HOUSTON CARDIAC ASSOCIATES AND AGREE TO ABIDE BY THE SAID POLICY.

√____ _________________________
Signature of Patient/Parent/Guardian Date

I will be paying today by: _____ Check _____ Cash _____ Credit Card

Please present both you insurance card and your driver's license or valid picture ID so we may make a copy for our records.

MONTGOMERY
HEART & WELLNESS

Houston Cardiac Association
Baxter Montgomery, M.D.

10480 Main St.
Houston, TX 77025

Phone: 713-599-1144
Fax: 713-599-1199

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposed: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be in sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about your treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent thatwe have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: Sean Johnson

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 1, 2008 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and tomake the new notice of provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to filewritten complaint with our office, or with the]Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will notretaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Houston Cardiac Association
Baxter Montgomery, M.D.

10480 Main St.
Houston, TX 77025

Phone: 713-599-1144
Fax: 713-599-1199

Acknowledgement of review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

I wish to have the following restriction to the use and disclosure of my health information:

____

____

____

I authorize you to disclose my private health information to:

______________________________________ ______________________________
Name and Relationship **Phone Number**

______________________________________ ______________________________
Name and Relationship **Phone Number**

√______________________________________

Signature of Patient or Personal Representative

____

Print Name of Patient or Personal Representative

____

Date

____
Description of Personal Representative Authority

FOR OFFICE USE ONLY
[ ] Consent Received by _________________________ on _________________________
[ ] Consent refused by patient and treatment refused as permitted.
[ ] Consent refused by patient, and treatment permitted as per ______________________
[ ] Consent added to patients medical record on __________________________________

Houston Cardiac Association

Dr. Baxter Montgomery
10480 Main St
Houston, TX 77025
Phone: (713) 599-1144
Fax: (713) 599-1199

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: ____

To: ____

____

____

Re: ____

DOB: _______________ **SS#:** _________________

The above mentioned patient who is presently being seen in our office was previously treated in your office/facility. In order to better evaluate the patient's clinical condition, we need the information requested below. Please forward them to:

Houston Cardiac Association c/o Baxter Montgomery, M.D., F.A.C.C. Fax Number 713-599-1199

The records desired are:

_________ **Dictated H&P/discharge summary, brief report of treatment rendered, or copies of the medical record.**
_________ **X-ray, ultrasound report/ films.**
_________ **Recent lab results.**
_________ **All cardiac diagnostic studies/procedures including heart cath, stress test, EKG, electrophysiology study, device implant, etc.**

Your prompt attention to this request is appreciated.

Authorization for Release of Medical Information

I hereby authorize and request Dr. Baxter Montgomery to furnish a copy of my medical records to Dr.

______________________________ covering dates ______________________ to ______________________

Patient signature:√ _________________________________ Date: _______________________

Witness signature: √_________________________________Date: _______________________

MEDICAL HISTORY QUESTIONEER

Name___________________________________ DOB: __________________ Date ____________________

REASON FOR TODAYS VISIT

____

____

ALLERGIES: ____

____

PATIENT HISTORY (PLEASE CIRCLE YES OR NO)

HIGH BLOOD PRESSURE	*YES NO*	
CORONARY ARTERY DISEASE	*YES NO*	
DIABETES	*YES NO*	
HIGH CHOLESTEROL	*YES NO*	
CONGESTIVE HEART FAILURE	*YES NO*	
POOR CIRCULATION	*YES NO*	
PACEMAKER OR ICD	*YES NO*	*IF YES: DATE_________________*
HEART ATTACK	*YES NO*	
SMOKER	*YES NO*	*IF YES: PACKS PER DAY ______*
COUGH	*YES NO*	
SHORTNESS OF BREATH	*YES NO*	
WHEEZING	*YES NO*	
BLOOD IN URINE	*YES NO*	
DIFFICULTY URINATING	*YES NO*	
NAUSEA	*YES NO*	
VOMITTING	*YES NO*	
DIARRHEA	*YES NO*	
CONSTIPATION	*YES NO*	
SKIN RASH	*YES NO*	
SWELLING	*YES NO*	
RECENT WEIGHT LOSS	*YES NO*	
FEVER	*YES NO*	

FAMILY MEMBER	*STILL LIVING*	*AGE*	*HEALTH CONDITION*
FATHER	*YES / NO*	_______	____
MOTHER	*YES / NO*	_______	____
SISTER	*YES / NO*	_______	____
SISTER	*YES / NO*	_______	____
BROTHER	*YES / NO*	_______	____
BROTHER	*YES / NO*	_______	____

Name**____ *DOB:* ___________________ Date ______________**

LIST SURGERIES

DATE *REASON*

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____

____

LIST HOSPITALIZATIONS

DATE *REASON*

____

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MAINTENANCE MEDICATIONS