Cardiology Center of Houston, P.A.

RANDEEP SUNEJA, MD, FACC, FSCAI, FCCP, FACP, FASNC
RAMAMANOHARA PAI, MD, FACC, FACP
KAMALAKANNAN DESIKAN, MD, FACC, MRCP (UK)
20710 Westheimer Parkway, Katy, TX 77450
Phone: 281.646.9000 Fax: 281.206.2311

PATIENT INFORMATION

Thank you for choosing Cardiology Center of Houston, P.A.

Dr. Suneja, Dr. Pai, Dr. Desikan and staff welcome you as a patient and appreciate the opportunity to serve you. Please complete the following information. This information will be kept confidential.

Please Print

Date_____ Patient Name_____

First MI Last

SSN_____ Birth date _____ Male_____ Female_____

Single___ Married___ Divorced___ Widowed___ Race: _____ Language: _____

Address_____

Street City State Zip

Please check which phone number is your preferred contact number below

□ Home Phone: _____ □ Cell Phone: _____

□ Work Phone: _____ Employer: _____

E-MAIL: _____

Emergency Contact:_____
Phone:_____
Relationship to Patient:_____

Referring Physician:_____
Address:_____
Phone:_____

Primary Care Physician (PCP):_____
Address:_____
Phone:_____

Pharmacy Name:_____
Address:_____
Phone:_____

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Insurance Assignment of Benefits

Primary Insurance

Name of Patient: _____

Name of Policy Holder: _____

Relationship to Patient:_____ Policy Holder DOB: _____

Policy Holder Employer Name:_____

Policy ID Number: _____**Policy Group Number:** _____

Secondary Insurance

Name of Patient: _____

Name of Policy Holder: _____

Relationship to Patient:_____ Policy Holder DOB: _____

Policy Holder Employer Name:_____

Policy ID Number: _____**Policy Group Number:** _____

I hereby instruct and direct _____ Insurance Company to pay by check made out for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Mail to: **Cardiology Center of Houston, P.A.**
20710 Westheimer Parkway
Katy, Texas 77450

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional charges over and above this insurance payment. I also understand that I am expected to know my benefits under this plan and do not expect Cardiology Center of Houston, P.A. to guarantee insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, referring or treating physician that may be involved in my care. I authorize the physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date at _____ this_____ day of _____, 20_____.

_____ _____

Signature of Policy Holder **Witness**

_____

Signature of Claimant, if other than Policy Holder

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FINANCIAL POLICIES

1. All co-pays, deductibles and co-insurances are due at the time of service.
2. Insurance benefits will be assigned to the physician. All insurances will be filed for the patient providing we are able to identify eligibility.
3. If insurance is found to be terminates after services are rendered it will be the responsibility of the patient to provide us with new insurance information or other form of payment.
4. Financial arrangements will be considered on an individual basis.
5. Balances will be turned over to our collection agency if not paid in a reasonable amount of time.
6. A discount may be arranged for patients that do not have insurance.
7. Statements will be mailed the first week of each month and payment is expected before the 30th of the same month.
8. We accept cash, check, Mastercard, Visa, Discover and American Express.
9. There will be $25.00 fee for all returned checks.
10. There will **NOT** be any interest charged on balances that are being paid off in a timely manner.
11. Referrals to our clinic, are occasionally required by insurance companies, this is the patient's responsibility to obtain his referral prior to coming to our office.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Name of Patient (print) Social Security Number

Disclosure and Acknowledgement of Physician Ownership

By signing below, I acknowledge that my physician may refer me to another healthcare facility in which he/she may have ownership for testing and/or surgical intervention. A disclosure of ownership details is posted in the clinic. A list of alternative facilities is available upon request. I acknowledge that I have the right to choose an alternate facility.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

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Notice of Advance Directive

Advanced Directive: a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.

□ I have a signed advanced directive or living will. I understand that I am responsible for providing a copy of this document to the Cardiology Center of Houston to put in my medical file.

□ I have a signed medical power of attorney, with _____ designated as my medical power of attorney. I understand that I am responsible for providing a copy of this document to the Cardiology Center of Houston to put in my medical file.

□ I do not have a signed advanced directive, living will, or medical power of attorney.

□ I decline to provide this information at this time.

_____ _____
Signature of Patient or Personal Representative Date

Responsible Party

Name of Person Responsible for Account _____

Relationship to Patient_____ Date of Birth_____

Address_____

Street City State Zip

Home #_____ Work # _____

Employer Name and Address_____

□ Yes This person is currently a patient at this office
□ No This person is not currently a patient at this office

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PATIENT HISTORY

Name_____ Age_____ Sex_____

Phone:_____Cell:_____Pharmacy:_____

Referring Physician _____

Allergies to Medicine(s) _____

Allergies to Food(s) _____

Reason for visit: Please check appropriately.

- □ Chest pain
- □ Shortness of Breath
- □ Palpitations (rapid heart beat)
- □ Dizziness
- □ Passing Out
- □ Swelling Feet
- □ Leg Pain
- □ Leg Ulcer

Personal History:

- Smoking _____Yes _____No _____Duration _____Amount
- Alcohol _____Yes _____No _____Duration _____Amount
- Non-prescription drugs _____Yes _____No _____Duration _____Amount

Family History:

- □ Heart Attack or Sudden Death earlier than 65 years old
- □ Stroke
- □ Diabetes Mellitus
- □ Hypertension
- □ High Cholesterol

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Past Medical History

- □ Diabetes Mellitus
- □ High Cholesterol
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Cancer
- □ Thyroid Problems

Past Cardiac History

□	Angina		
□	Stroke/TIA		
□	Heart Catherization	Date:_____	Hospital:_____
□	Stents	Date:_____	Hospital:_____
□	Coronary Bypass	Date:_____	Hospital:_____
□	Pacemaker	Date:_____	Company:_____
□	Defibrillator	Date:_____	Company:_____
□	Peripheral artery stents	Date:_____	Hospital:_____

Past Surgical History

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Current Medications	Dosage	Number of Times Per Day

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Notice of Privacy Practices

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

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professional for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to day activities and management of Cardiology Center of Houston, P.A. for example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality,

Law enforcement: Your health information may be disclosed to law enforcement agencies are required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authoring a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that your may find interesting on the treatment or management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fundraising: Unless you request us not to, we will use your name and address to support our fund-raising effort. If you do not want to participate in fund-raising efforts, please check off the following box.

- ☐ Please do not use my information for fund-raising purposes.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of our protected health information.
- The right to receive confidential communication concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of the notice.

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Cardiology Center of Houston, P.A. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practiced that are outlines in this notice.

Right to revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to inspect protected health information

You may generally insect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You obtain a form to request access to your records by contacting, Keeper of Medical Records. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

McKayla Green, Office Manager
Cardiology Center of Houston, P.A.
20710 Westheimer Parkway
Katy, Texas 77450
281.646.9000

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause for your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is :

McKayla Green, Office Manager
Cardiology Center of Houston, P.A.
20710 Westheimer Parkway
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Effective Date

This notice is effective on or after March 28, 2016.

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Acknowledgment of Notice of Privacy Practices

This notice serves as acknowledgement that I have read, understand, and have received a copy of the Notice of Privacy Practices for Cardiology Center of Houston, P.A.

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Patient Name (Please Print) **Date**

Authorization for Disclosure of Protected Health Information

I authorize Cardiology Center of Houston, P.A. to disclose my protected health information (PHI) to my family member(s) and/or friend(s) for the purpose of information, treatment and health care.

I understand that this authorization is valid until the time if and when it is revoked in writing.

□ Yes Name of Person Authorized for disclosure of my Protected Health Information

_____

Relationship to patient _____

□ No

Signature _____ Date _____

Print Name _____

Witness _____

06.26.2024

AGREEMENT TO ARBITRATE HEALTH CARE NEGLIGENCE CLAIMS
NOTICE TO PATIENT

YOU CANNOT BE REQUIRED TO SIGN THIS AGREEMENT IN ORDER TO RECEIVE TREATMENT. BY SIGNING THIS AGREEMENT, YOUR RIGHT TO TRIAL BY A JURY OR A JUDGE IN A COURT WILL BE BARRED AS TO ANY DISPUTE RELATING TO INJURIES THAT MAY RESULT FROM NEGLIGENCE DURING YOUR TREATMENT OR CARE AND WILL BE REPLACED BY AN ARBITRATION PROCEDURE. THIS AGREEMENT MAY BE CANCELLED WITHIN 60 DAYS OF SIGNING OR 60 DAYS AFTER YOUR HOSPITAL DISCHARGE OR 60 DAYS AFTER YOUR LAST MEDICAL TREATMENT IN RELATION TO HEALTH CARE SERVICES NOT RENDERED DURING HOSPITALIZATION.

THIS AGREEMENT PROVIDES THAT ANY CLAIMS WHICH MAY ARISE OUT OF YOUR HEALTH CARE WILL BE SUBMITTED TO A PANEL OF ARBITRATORS, RATHER THAN TO A COURT FOR DETERMINATION. THIS AGREEMENT REQUIRES ALL PARTIES SIGNING IT TO ABIDE BY THE DECISION OF THE ARBITRATION PANEL.

To be completed by Provider's authorized representative:

Reason for Patient's services rendered:	
Date of services rendered to Patient:	
Signature of Provider's Authorized Representative:	
Date:	

To be completed by Patient or authorized representative:

Patient Name:	
Signature of Patient or Patient's Legal Representative	
Date:	
If signed by someone other than Patient, indicate relationship to Patient:	
I have the authority to execute this Agreement on the Patient's behalf:	