DALLAS CARDIOVASCULAR SPECIALISTS

Registration Form

Last Name_____ First_____ MI___

Sex (select):☐Male ☐Female Race: _____

Date of Birth _____ Social Security #_____ Marital Status: _____

Address_____ Apt# _____

City_____ State_____ Zip_____

Phone Numbers: Home: _____ Work/Cell: _____

Email:_____

For purposes which may include patient survey, patient newsletter, and/or medical alerts such as medication recalls only.

Employer's Name: _____ Occupation: _____

How did you hear about us? _____

Referring Physician _____ Primary Care Physician _____

Emergency Contact Person:_____ Relationship:_____

Primary Number: _____ Secondary Number: _____

Insurance

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance: _____

***If you are not the policy holder please complete the following information ***

Policy Holder's Name:_____ Date of Birth: _____ Policy #_____

Secondary Insurance: _____

***If you are not the policy holder please complete the following information ***

Policy Holder's Name:_____ Date of Birth:_____ Policy #_____

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Dallas Cardiovascular Specialists. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Patient or Personal Representative **Date**

Financial acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative **Date**

CONTINUE ON BACK

Acknowledgement of Review of Notice of Privacy Practices

_____**Initial**- I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Please select all that apply below.

☐ I give permission to leave a message on my voicemail concerning my personal health information.
☐ I do not give permission to leave a message on my voicemail concerning my personal health information.
☐ I hereby give permission to communicate via email, which may include appointment reminders, patient survey, patient newsletter, and/or medical alerts such as medication recalls. My email address is on the front of this form. We do not release personal information to third party vendors; it is for DCS use only.

General Consent for Care and Treatment Consent

_____**Initial**- This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a Dallas Cardiovascular Specialists physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Dallas Cardiovascular Specialists. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	Description of Representative's Authority
Printed Name of DCS Witness	Signature of DCS Witness

Date:_____

Dallas Cardiovascular Specialists Patient HIPAA Form

Release of Information

_____**Initial** I hereby permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosure to Families and Loved Ones

I authorize Dallas Cardiovascular Specialists to disclose information to family and friends. (For example, you may prefer a family member or friend to be present in the exam with you, or you may prefer someone (i.e. spouse, parent, child) to be allowed to discuss your health care with us.) Without authorization, no information will be shared. **I request that my personal health information be shared with the following people:**

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

☐ I do not authorize Dallas Cardiovascular Specialists to disclose my information to family and/or loved ones. _____**Initial**

Please note this disclosure will remain valid until a new written authorization is completed.

DISREGARD THIS PAGE.

THIS CURRENTLY DOES NOT APPLY TO DALLAS CARDIOVASCULAR SPECIALISTS.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____**Initial** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____
Patient/Patient Representative Signature: _____
Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____**Initial** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.