Today's Date: _____

Houston Arrhythmia Associates, P.A.

Sohail Jalal, M.D. Alexander Drtil, M.D.

Patient Information:

Patient Name:		Gender/Sex:	☐M ☐ F ☐T
Birthdate:		Age:	
Social Security #:			
Home Address:		Zip Code: State:	
Phone #:		Alternate #:	
Spouse's Name (if applicable):		Relationship Status:	☐Single ☐Married ☐Significant Other ☐Widowed ☐Divorced ☐Separated
Occupation and Employer:		If student, school name:	

Emergency Contact:

Name:		Relationship:	
Phone #:		Alternate #:	

Insurance:

Primary:		ID #: Group #:	
Secondary:		ID #: Group #:	

Physicians:

Primary Care:		Referring:	
Cardiologist:		Other:	

Pharmacy:

Preferred Pharmacy:		Pharmacy Phone #:	
Location:			

Today's Date: _____

Family History: Please check/mark all that apply

	Living	Deceased	Heart Disease	Hypertension	Diabetes	Stroke	Other
Mother							
Father							
Siblings							
Children							

Social History:

Smoking	☐Non-Smoker ☐Former Smoker ☐Current Smoker ☐Other Tobacco	If current smoker, how much per day?	
Caffeine	☐Yes, type: _____ ☐No	If yes, how much and how often?	
Alcohol	☐Yes, type: _____ ☐No	If yes, how much and how often?	
Exercise	☐Yes, type: _____ ☐No	If yes, how much and how often?	

Relevant Surgical History:

	Date:
	Date:
	Date:

Hospitalizations: Please list any recent or cardiac related hospitalizations

	Date:
	Date:
	Date:

Meaningful Use Patient Response: Please select from the following

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American ☐White ☐Hispanic ☐Native Hawaiian ☐Other Pacific Islander ☐Other Race ☐Unreported/Refuse to Report

Ethnicity: ☐Hispanic or Latin ☐Not Hispanic or Latin ☐Unreported/Refuse to Report

Language: ☐English ☐Spanish ☐Russian ☐Indian (includes Hindi and Tamil) ☐Other ☐**Translator Needed**

Patient Health Portal Access

Please provide an email address so we may enable you to access your health information online:

Email Address: _____

☐I do not want to share my email ☐I have no interest in the portal ☐I do not have email

Designation and Direction for Release of Medical Information

I _____ (patient name) hereby authorize my protected health information to be discussed/disclosed as necessary to the person(s) named below as required for my medical treatment.

Patient Personal Representative (who we can release information to):

_____

Relationship to Patient: _____

Patient Signature: _____

Date: _____

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Privacy Policy

In order to continue to provide you with the quality care you have become accustomed to in our office, as well as operate in an efficient manner, we will need to access your private health care information for the purposes of treatment, payment, and operations (such as quality assurance). In using this information, this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy & security protections provided to you by the Health Insurance Portability and Accountability Act (HIPAA).

Specifically, we will need to disclose your private information under the following circumstances:

- **Sharing information for the purpose of treatment.** We will share information with all members of your treatment team, both within this office and with other providers (personal and institutional) in order to provide you quality care and the educational/wellness programs specified in your insurance plan.
- **Sharing of information for the purpose of payment.** We will share all necessary information with your insurer(s), payor(s), government entities (such as Medicare, Medicaid, etc.), and their representatives (including, but not limited to) benefit determination and utilization review as well as representatives involved in the billing process (including but not limited to) claims representatives and billing companies.
- **Sharing information for purposes of operations.** We will share information necessary for ongoing operations of this office, including (but not limited to) credentialing process, peer review, accreditation, and compliance with all federal and state laws.

Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

Your signature indicates your consent has been given freely. You understand that you may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Patient Name: _____

Patient Signature: _____

Date: _____

Today's Date: _____

Houston Arrhythmia Associates, P.A.

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Financial Policy Agreement

We, the staff of Houston Arrhythmia Associates, P.A., thank you for choosing us as your health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest quality care and building a successful prover-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship, and our goal is to not only inform you of the provisional aspects of that financial policy, but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact our office. We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service **unless a payment arrangement has been approved in advance by our staff**.

We accept payments for your convenience, including cash, money order, MasterCard, Visa, Discover, American Express, and in-state checks. A $25.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience, knowing that we adhere to the highest level of information security.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Collection Agency

If no attempt is made to take care of upstanding balance **after 180 days**, it will be placed with our Collection Agency. Interest will be applied along with the report to the Credit Bureau and **no further office visits will be scheduled** until payment plan with a card on file is saved or balance is paid in full.

Insurance

Please remember that your insurance is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to **notify our office of any information changes when they occur.** Even a **pre-authorization of services does not guarantee payment** from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participation with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, **we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier**.

Please be aware that **out-of-network** insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. **Our fees are well within such ranges** and although we will assist in the filing of an appeal, if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of the claim forms for school, sports, or extracurricular activities, there will be an administrative fee, not to exceed $25.00, for the additional information.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us in advance, a missed appointment fee will apply. These fees are typically $25.00, but not to exceed one half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to be compensated for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner, but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understood the above financial policy. I agree to assign insurance benefits to Houston Arrhythmia Associates whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Insured or Authorized Representative Name: _____

Signature: _____

Date: _____