Heart Clinic of San Antonio

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Information:

Last Name: _____ First Name: _____ Middle Initial:_____

Date of Birth: _____ Sex: ____Male ____Female SS#:_____ Marital Status:_____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Contact Preference: (Home Phone) (Work Phone) (Mobile Phone) (Mail) (Patient Portal)

Referring Provider: _____ Patient PCP: _____

Race: (Arab) (Asian) (Black or African American) (Other Race) (White) (Other) Preferred Language: English Other _____

Ethnicity: (Central American) (Cuban) (Dominican) (Hispanic or Latino/Spanish) (Latin American/Latin, Latino) (Mexican) (Not Hispanic or Latino) (Puerto Rican) (South American) (Spaniard)

How did you hear about us? (Physician) (Internet Search) (Newspaper) (Television) (Hospital Partner) (BHS Screening Bus) (Baptist Community Event) (Website) (Insurance Company) (LoneStar FastCare) (Baptist Emergency Hospital) (Friend/Family) (Employer) (Other _____)

Emergency Contact Information:

Last Name:_____ First Name:_____ Phone:_____ Relationship:_____

Insurance Information: *Please bring insurance card(s) to the visit*

Insurance Plan Name: _____ Policy Holder Name: _____ Policy Holder DOB: _____

Protected Health Information Authorization:

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name	Relationship to Patient	Type of information			
		All	Schedule	Medical	Billing
_____	_____	Y/N	Y/N	Y/N	Y/N
_____	_____	Y/N	Y/N	Y/N	Y/N
_____	_____	Y/N	Y/N	Y/N	Y/N
_____	_____	Y/N	Y/N	Y/N	Y/N

Specific Instructions or Limitations:_____

_____

We will continue to rely on the information given here when communicating with family members or others involved in you care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature of Patient:_____ **Date:**_____

To revoke this authorization, please send a written request to our office.

If you have any questions please call our office and ask for the Practice Coordinator or Practice Manager.

HEART CLINIC OF SAN ANTONIO POLICY ACKNOWLEDGEMENTS AND RELEASES

Please read each of the following statements carefully and sign as your authorization, understanding, and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

Signed: _____ Date: _____

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by _____. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: _____ Date: _____

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed: _____ Date: _____

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: _____ Date: _____

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)?

_____Yes _____No If yes, please provide a copy for our records.

NO SHOW POLICY

Patients who fail to present for a scheduled appointment without contacting the practice to cancel the appointment within 24 hours will be considered a "no-show". Patients who consistently fail to present for scheduled appointments will be considered a "chronic no-show".

A patient determined to be a "chronic no-show" will be charged $25.00 after the 3rd missed appointment. A patient determined to be a "chronic no-show" may be discharged from the practice.

A chronic "no-show" is defined as having 3 missed appointments in a rolling 12-month period.

_____ has read and understand the above stated policy.
Patient Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: You may refuse to sign this acknowledgement.

I, _____, DOB, _____,

have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____Individual refused to _____accept Notice _____ sign Acknowledgment

_____Communications barriers prohibited obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgment

Other (Please specify)

_____

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. PLEASE REVIEW IT CAREFULLY.

Effective: 7/9/12

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments: Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying services. An example would be your health plan may request and receive information on dates of service, services provided and medical condition being treated.

Legal: Your health information may be disclosed to public health agencies as required by law. An example would be if we are required to report some communicable diseases to the state's public health department.

Other uses and disclosures requiring authorization: Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information: Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Individual Rights

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

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

Arrhythmia Associates of South Texas Duties: We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Revising Privacy Practices: We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect 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 may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Required by Law: Federal, state, and local laws sometimes require us to disclose patients' medical information. For instance, we are required to report child abuse or neglect and must provide certain information to law enforcement officials in domestic violence cases. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

Clinic Operations: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run the offices. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate whether office personnel, your doctors, or other health care professionals did a good job.

Concerns or Complaints: Please tell us any problems or concerns you may have with your privacy rights. If you have a concern, please contact: Corporate Privacy Official at **1-888-895-9945** or Corporate Compliance Hotline at **1-800-300-9876.** You can also send a complaint to the Secretary of DHHS, instead of or in addition to our Corporate Privacy Official if you believe your privacy rights have been violated.

A covered entity may not require individuals to waive their rights to file a complaint as a condition of the provision of treatment, payment, enrollment in a health plan or eligibility for benefits. Nor may it intimidate or retaliate against complainants, be they patients/customers or members of the workforce.

Questions: Please contact

BHS Physicians Network- HIPAA Privacy Officer
8711 Village Drive, Suite 118 San Antonio, TX 78217
210-297-2245