



NORTHWEST HOUSTON HEART CENTER

INSURANCE INFORMATION

Do you have Medicare? ☐ Yes ☐ No If yes, your Medicare ID# _____

Primary Insurance Name _____ Policy Holder _____

Relation ☐ Self ☐ Spouse ☐ Other ID# _____ Group# _____

Secondary Insurance Name _____ Policy Holder _____ Relation ☐ Self ☐ Spouse ☐

Other ID# _____ Group# _____

PATIENT DEMOGRAPHICS

Name _____ DOB _____ Age _____

Last

First

Middle

Gender ☐ Male ☐ Female Status ☐ Single ☐ Married ☐ Other _____

Race/Ethnicity ☐ White ☐ Hispanic ☐ Black/African American ☐ Asian ☐ Other _____

Address _____ City _____ State _____ Zip _____

Home# _____ Cell# _____ Work# _____

Email _____

Occupation _____

Emergency Contact _____ Relation _____ PH# _____

308 Holderrieth Blvd
Tomball, TX 77375

18230 FM 1488
Magnolia, TX 77354

21216 NW Fwy Ste 640
Cypress, TX 77429

Phone: 281-351-4911 • Fax: 281-351-4915 • www.houstonheartcenter.com



NORTHWEST HOUSTON HEART CENTER

PATIENT FINANCIAL POLICY AND CONSENT FORM

Patient Financial Policy

We are dedicated to providing the best possible care and service to our patients. To avoid confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager.

Fees and Payments

We share your concerns about rising health care costs. Our fees represent usual and customary charges based on community standards. Patients are expected to pay for professional services at the time of the visit. Our policy is to collect the co-payment when you arrive for your appointment. All forms of payment are accepted including cash, personal checks, debit cards and credit cards including MasterCard, Visa, American Express, and Discover. If you have any questions about our fees, please feel free to discuss with us.

Insurance

We have a contract with many health plans to accept an assignment of benefits. We will bill these plans and will require the patient to pay authorized co-payments, coinsurance, and deductibles at the time the services are rendered. The responsibility for payment of medical care costs is the direct responsibility of the patient. The remaining balance is due within one month of notice from the insurer. The patient is responsible for obtaining authorization from his or her primary care physician. The patient is responsible for understanding the authorization process and the payment process of his or her insurance company.

Physician Authorization and Assignment of Benefits

I hereby authorize Northwest Houston Heart Center to release any medical information and diagnosis requested by my insurance company and my treating physicians. I understand that this information will include, where applicable, all the work up, testing, diagnosis and treatment. Treatment plans also including all blood work and specific laboratory test results including HIV testing for the diagnosis of acquired immune deficiency syndrome. I further authorize payment directly to the assigned physician for the surgical and or medical payables under my plan for services provide to me.

Authorization to Release Medical Records

I am writing to authorize Northwest Houston Heart Center to obtain my medical records on my behalf. Please send my medical records by fax at 281-351-4915 or by mail at the following address: 308 Holderrieth Blvd Tomball, TX 77375-4536

Advance Beneficiary Notice of Noncoverage (ABN)

You are receiving this notice because your insurance company may not pay for all the services that you receive during your visits to our office. You need to read this notice so that you can make an informed decision about your care. If your insurance carrier denies payment, then you are completely responsible for payment in full to the services rendered to you at this facility., You understand that you can appeal this decision for nonpayment to your insurance carrier. By this notice, you agree to take financial responsibility for the cost of the supplies and services rendered to you at your visit to our facility, if your insurance company denies coverage for the same. If you do not want any service not covered by your insurance company, please inform us in writing at the time of check in.

Patient Signature _____ Date _____

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Primary Care Physician (If applicable): _____

Referring Doctor (if applicable): _____

Reason for your visit? _____

Any Abnormal Symptoms or Question or Concerns you want to be addressed in today's visit?

The following is based on the **PATIENTS PAST MEDICAL HISTORY**

PAST MEDICAL HISTORY	PATIENT HISTORY	PAST MEDICAL HISTORY	PATIENT HISTORY
Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Cardiac Arrest	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Pacemaker Placement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Angioplasty/stent of heart arteries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Defibrillator placement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Peripheral Vascular Disease (PAD/PVD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Congestive heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Abdominal Aortic Aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Kidney/Renal problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Atrial Fibrillation/Atrial flutter	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		

The following is based on the patients **FAMILY HISTORY**

FAMILY HISTORY	FAMILY HISTORY	If YES, please write relation and age at diagnosis
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Relation..... Age
Angioplasty/stent of heart arteries or bypass surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Relation..... Age
Angioplasty/stent/surgery of leg arteries or Carotid arteries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Relation..... Age
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Relation..... Age
Congestive heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Relation..... Age
Pacemaker Placement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Relation..... Age



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Current Medications with Dosages, please bring all your pill bottles with you for your first appointment
Please enlist them here or give them to staff when you get into exam room

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

Recent Hospitalization in the last 3 months? Yes No

If yes, please specify when/where/and reason _____

Allergies to any medications? Yes No

If yes, please list the name of medication(s) and type of reaction _____

Allergy to Iodine Dye? Yes No Unknown

This dye is generally given during Angiogram or CT scan

If yes, please describe kind of reaction _____

Patient Name _____

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Social History

Are you married? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No How many cigarettes per day? _____

Have you ever been a smoker? ☐ Yes ☐ No How many per day? _____ How long? _____

Do you currently drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____

Do you use recreational drugs? ☐ Yes ☐ No

Check all that apply (Review of Systems)

Constitutional	<input type="checkbox"/> Weight gain <input type="checkbox"/> Fever <input type="checkbox"/> Restless sleep <input type="checkbox"/> Weight loss <input type="checkbox"/> Snoring <input type="checkbox"/> Fatigue
Eyes	<input type="checkbox"/> Change in visual acuity <input type="checkbox"/> Double vision <input type="checkbox"/> Vision loss
ENT	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Enlarged Lymph Nodes <input type="checkbox"/> Hearing loss <input type="checkbox"/> Sore throat
Cardiology	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart murmur <input type="checkbox"/> Syncope/Passing out
Respiratory	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Phlegm
Gastroenterology	<input type="checkbox"/> Polyps <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcers <input type="checkbox"/> Liver disease
GU	<input type="checkbox"/> Kidney disease <input type="checkbox"/> Bladder problems
Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Leg cramps <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Sciatica <input type="checkbox"/> Back Pain
Psychiatrics	<input type="checkbox"/> High stress level <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
Endocrinology	<input type="checkbox"/> Weight loss <input type="checkbox"/> Cold/Heat intolerance <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid abnormalities
Neurology	<input type="checkbox"/> Headache <input type="checkbox"/> Tingling/Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Memory loss <input type="checkbox"/> Gait abnormality
Dermatology	<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Skin cancer <input type="checkbox"/> Frequent bruising

CIRCULATION QUESTIONNAIRE

Vein circulation questions, Do I Need a Test for Chronic Venous Insufficiency?

Are your legs swollen, painful, red, or warm to the touch?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have varicose veins (veins that are enlarged/swollen and raised) in the legs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, cellulites, or non-healing ulcers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your legs feel heavy, tired, restless, or achy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you push on your swollen foot, ankle, or leg for 10 seconds and release, does it leave a dimple?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If your feet, ankles and legs are swollen, does the skin look stretched or shiny?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an ulcer on the inside of your ankle?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Arterial Circulation questions, Do I need a Test for Peripheral Arterial Disease?

Do you have foot/calf/buttock/hip/thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience any pain at rest in your lower leg(s) or feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience foot or toe pain that often disturbs your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are your toes or feet pale, discolored, or bluish?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have skin wounds or ulcers on your feet or toes that are slow to heal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you suffered a severe injury to the leg(s) or feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	<input type="checkbox"/> Yes <input type="checkbox"/> No