LONE STAR
Cardiovascular Institute

PATIENT REGISTRATION

Patient Demographics

Patient Name:	DOB:
Address:	SSN:
City, State, Zip:	☐ Male ☐ Female ☐ Other
Home #: Mobile #:	☐ Single ☐ Married ☐ Divorced
Email:	Preferred: ☐ Phone ☐ Email

Employer Information

Employer:	Work #:

Guarantor Information

Guarantor Name (If different from patient):	
Address:	SSN:
City, State, Zip:	Relation:

Emergency Contact Information

Name:	Relation:	Phone #:
Name:	Relation:	Phone #:
Name:	Relation:	Phone #:

Primary Care Physician & Referring Physician Information

Primary Care Physician:	Phone #:
Referring Physician:	Phone #:

Pharmacy Information

Pharmacy Name:	Phone #:
Address:	Fax #:
City, State, Zip:	Mail ID (if applicable):

Texas Law and Federal Regulations require the following information. Please initial if you decline to provide.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	I Decline to Provide:
Race: ☐ American Indian/Eskimo ☐ Asian/Pacific Islander ☐ African American ☐ White ☐ Other/Multi-Racial	

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ASSIGNMENT OF BENEFITS

Financial Responsibility

Self-Pay Patient (please initialize to verify you will not be using insurance)	Initials:
Primary Insurance Name:	ID:
Subscriber (if different from patient):	Group #:
Address:	Phone #:
Secondary Insurance Name:	ID:
Subscriber (if different from patient):	Group #:
Address:	Phone:

I understand that services rendered to me by Lone Star Cardiovascular Institute are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Lone Star Cardiovascular Institute and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY.

I may be required to pay my **estimated** deductible and co-insurance at the time of service knowing that the claim must be paid within all state or federal, prompt payment guidelines. I have chosen to assign the benefits and will provide all relevant and accurate information to facilitate payment of the claim. I authorize the provider to release any information necessary to adjudicate the claim. I authorize payment for all medical and surgical benefits to which I am entitled, through private, commercial, employer, or government health plans, including major medical benefits, be made to Lone Star Cardiovascular Institute. I authorize any holder of information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or other benefits related to these services. I appoint Lone Star Cardiovascular Institute, to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

I also understand that should my insurance company send payment to me, I will forward the payment to Lone Star Cardiovascular Institute. I agree that if I fail to send the payment and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable. I request that payment of authorized Medicare benefits made on my behalf for any services furnished to me by Lone Star Cardiovascular Institute, or on its premises, including physician services.

The above information is true to the best of my knowledge. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, regardless of payment by said insurance company. I hereby authorize Lone Star Cardiovascular Institute to release all information necessary to secure payment.

Date: _____

Patient: _____
Signature of patient or responsible party

_____
Printed name of patient or responsible party (relationship if not self)

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TRANSFER OF CARE RELEASE OF PROTECTED HEALTH INFORMATION

Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out on each patient **annually**. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization outlined below.

Patient Name:	DOB:
Full Address:	Phone:

I authorize _____ to disclose my protected health information for continuance of care under the supervision of the entity outlined below.

Person/Organization Name:	
Address:	Phone #:
City, State, Zip:	Fax #:

Person/Organization Name:	
Address:	Phone #:
City, State, Zip:	Fax #:

Information Authorized to Disclose:

☐ All health information	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Physician's Orders	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ Other_____

Initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)	_____ HIV/AIDS Test Results/Treatment
_____ Genetic Information (including Genetic Test Results)	_____ Drug, Alcohol, or Substance Abuse Records

Date: _____

Patient: _____
Signature of patient or responsible party

_____
Printed name of patient or responsible party (relationship if not self)

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PRACTICE POLICY AND CONSENT

At Lone Star Cardiovascular Institute, our goal is to empower you with the knowledge and tools to maintain a strong, healthy, and controllable heart for life. We utilize state-of-the-art transthoracic echocardiography, vascular imaging, and nuclear medicine to assess heart performance with precision, management for continued monitoring, programming, and maintenance of implanted cardiac devices to ensure optimal function and meet each patient's unique cardiac needs.

Scheduling Your Appointment
To schedule your appointment, or if you must cancel an appointment, please call (682) 428-7711. Please listen carefully to the options provided.

Your appointment may include one or more diagnostic tests used to determine how your heart is functioning. Due to the comprehensive exam that will be done, and the possible need for diagnostic testing, you should wear comfortable clothing and shoes. Additionally, to help our team develop a treatment plan that is best for you, it is necessary that you bring all your current medications with you every visit.

Your Appointment
On the day of your appointment, please:

- Be prepared to pay for your copay and any patient balance on your account
- Have your insurance card and ID available to copy into your chart
- Bring all medications that you are currently taking
- Wear comfortable clothing and walking shoes
- Bring studies or reports performed by your referring physician
- If you would like a chaperone for your visit, please notify our front desk team

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.

On occasion, Dr. James may be requested to attend an unscheduled emergency away from the office due to his level of expertise and skill. If this should occur during your appointment, every effort will be made to accommodate your needs. Depending upon the nature of the emergency, you may be asked to wait for Dr. James to return. Otherwise, we may ask to reschedule your appointment for another day or to see his nurse practitioner, Jennifer Becerra.

Payment Policy
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. **No-show fees will be assessed for the following appointment types: Office Visit = $25.00 | Diagnostic Study = $50.00 | Nuclear Study = $200.00.**

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. A pre-authorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating 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. We currently do not offer payment plans, but we work with our patients on a one-on-one basis should financial issues arise.

Date: _____

Patient: _____
Signature of patient or responsible party

_____
Printed name of patient or responsible party (relationship if not self)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Lone Star Cardiovascular Institute is to serve our customers with professionalism and care, always being sure to protect the privacy and security of all Protected Health Information. While serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- During healthcare operations, we may need a second opinion.
- During payment purposes, we may need to share medical records, progress notes, operative reports, etc.
- For collection purposes, we may use the services of a third-party collection company.

Lone Star Cardiovascular Institute and our staff are committed to obeying all federal, state and local laws and regulations regarding privacy practices. If there are any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

I understand that as part of the provision of healthcare services Lone Star Cardiovascular Institute creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that I have the right to review the Notice of Privacy Practices before signing this consent (Please request a copy from the receptionist if you wish to review). I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent. This consent is given freely with the understanding that:

1. All records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.
4. I have read and understand the above Notice of Privacy Practices.

Date: _____

Patient: _____
Signature of patient or responsible party

_____
Printed name of patient or responsible party (relationship if not self)

4900 BOAT CLUB ROAD | FORT WORTH, TX 76135 | PHONE 682.428.7711 | FAX 817.238.6291

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FINANCIAL AGREEMENT

Lone Star Cardiovascular Institute believes 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. We believe this level of communication and cooperation will allow us to continue to provide quality service to our valued patients.

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 require copayments, estimated coinsurance and deductibles, and past-due balances at time of service. We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa and in-state 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.

Insurance
Please remember that your insurance policy 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 have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. 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. Photo ID and insurance cards will be copied into your chart. Even an authorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating 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.

Selfpay
Patients who do not have insurance or who wish to opt out of using their medical benefits are required to pay in full at the time of service. Partial payments will not be accepted unless prior arrangements have been approved by our office.

Missed Appointments and Additional Fees
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 appointments without notifying us in advance: a missed appointment fee will apply. Fees are determined by the services that would've been performed. A $35.00 service fee will be charged for all returned checks. Additionally, providers also have the right to compensation for medical records that aren't transferred to other providers, and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files and or summaries.

Office Visit = $25.00 | Diagnostic Study = $50.00 | Nuclear Study = $200.00 | Monitor Daily Non- Return = $25.00

Date: _____

Patient: _____
Signature of patient or responsible party

_____
Printed name of patient or responsible party (relationship if not self)