	TUTE OF EAST TEXAS		Please circle the Doct	or you are here to see
Date			Ravinder Bachireddy, MD	Ilyas M Khan, MD
			J S Chandra, MD	Yugandhar Manda, MD
How did you hear abo	out The Heart Institute?		Venkata R Kovvali, MD	George Vettiankal, MD
Physician Referral			Kevin L Hudson, DO	Aditya Saini, MD
Friend	Other Please Specify		M. Musa Khan, MD	Mikkhail Narezkin, MD
	= other freude speen) _		Cheriparambil K Mani, MD	Subramanya Venkata, MD
Patient Informa	tion			
Name	first	middle Social Se	curity # last 4 digits only xxx-x	x
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Home Ph	Bus	inoss Ph ()	CellPh.(
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□ Married □ Single	e 🗆 Widow 🗖 Divorced	AgeDate of	Birth	Male 🗖 Female
Employer Name			🗖 Student - Fulltime	
GFull-Time	Part-Time 🗖 Retired	Self-Employed	Student - Fulltime	Student – Part-time
Primary Care Physicia	PhysicianReferring Physician			
Pharmacy		Allergies		
	If no insurance, resp			
			Relationship	
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Address		City/State	/Zip	
Phone #	Cell	#		
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Acknowledgement of Review of Privacy Practice

I have reviewed this office's *Notice of Privacy Practice* which explains how my medical information will be used and disclosed. I have been given the opportunity to ask questions if I do not understand.

I understand that I am entitled to receive a copy of this document.

Signature of Patient or Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Ravinder Bachireddy, MD	Kevin L Hudson, DO
J S Chandra, MD	M. Musa Khan, MD
Venkata R Kovvali, MD	Cheriparambil K Mani, MD
Ilyas M Khan, MD	Aditya Saini, MD
Yugandhar Manda, MD	Mikhail Narezkin, MD
George Vettiankal, MD	Subramanya Venkata, MD
Jamie Huckabee, APRN, NP-C, AACC	
Adam Merritt, APRN, NP-C	
Daniel Morris, APRN, NP-C	



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

• The practice may condition receipt of treatment upon execution of this consent. May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

This consent was signed by: ______ (PRINT NAME PLEASE)
Signature: _____ Date: _____

Witness: _____ Date: _____



Medical Records Release Form

То:							
Doctor or Hospital							
Address							
I hereby authorize and	request you to release	to:					
Name:							
Address:							
Phone:		_Fax:					
The complete medical r	ecords in you possessi	ion concern	ing my illness and/	or treatment:			
Records Requested:							
Time Period: To:							
Reason for release:							
	f this information may be p	rotected by P	ublic Law 93-255, sectio	osychiatric, alcohol, drug abuse, and on408: Public Law 93-282, Section sclosure by the recipient is			
Patient or Nearest Relat	ive		Relation to Patient				
Witness			Date				
Printed name of patient			Patient's date of bi	irth			
			SSN				
Ravinder Bachireddy, MD J S Chandra, MD Venkata R Kovvali, MD	Kevin L Hudson, DO M. Musa Khan, MD C K Mani, MD		han, MD ar Manda, MD ⁄ettiankal, MD	Aditya Saini, MD Mikhail Narezkin, MD Subramanya Venkata, MD			

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You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

• You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

• If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate inwriting within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the healthcare provider or facility gives you a Good Faith Estimate the healthcare provider or facility gives you a Good Faith Estimate before you schedule an item or service. If you do, make sure the healthcare provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.

• If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

• Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.