

THE HEART INSTITUTE OF EAST TEXAS

Date _____

How did you hear about The Heart Institute?

- Physician Referral Advertisement
- Friend Other Please Specify _____

Please circle the doctor you are here to see:	
Ravinder Bachireddy, MD	Yugandhar Manda, MD
J S Chandra, MD	Cheriparambil K. Mani, MD
Kevin L Hudson, DO	Vivek Menon, MD
Ilyas M Khan, MD	Harshil Patel, MD
M. Musa Khan, MD	Subramanya Venkata, MD
Venkata Kovvali, MD	George Vettiankal, MD

Patient Information

Name _____ Social Security # last 4 digits only xxx-xx-_____

Address _____ City _____ State _____ Zip _____

Home Ph. _____ Business Ph. (____) _____ Cell Ph. (____) _____

Married Single Widow Divorced Age _____ Date of Birth _____ Male Female

Employer Name _____
 Full-Time Part-Time Retired Self-Employed Student - Fulltime Student - Part-time

Primary Care Physician _____ Referring Physician _____

Pharmacy _____ Allergies _____

Insured Name (If no insurance, responsible party)

Name _____ Relationship _____

Social Security # _____ Date of Birth _____

Address _____ City/State/Zip _____

Phone # _____ Cell# _____

Employer Name _____ Employer Address _____

Notify In Case of Emergency

1. Name _____ Relationship _____ Phone (____) _____

2. Name _____ Relationship _____ Phone (____) _____

Insurance Information - Copies of Insurance Cards and Drivers License are Required

Insurance 1 _____
SS# _____ Policy# _____ Group# _____

Insurance 2 _____
SS# _____ Policy# _____ Group# _____

Authorizations

For and in consideration of the services rendered by THE HEART INSTITUTE OF EAST TEXAS, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgments obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign THE HEART INSTITUTE OF EAST TEXAS all rights, title and interest in any payment due me for services described herein as provided in the above mentioned policies of insurance/settlements or judgments. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signed _____ Date _____

Patient Name (Please Print) _____

Witness Signature _____ Date _____



THE HEART INSTITUTE

OF EAST TEXAS, P. A.

Specializing in Heart & Vascular Care Since 1982.

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

Amy Conrad, APRN, NP-C

J S Chandra, MD

Sheila Franklin, APRN, NP-C

Kevin L Hudson, DO

Jamie Huckabee, APRN, NP-C

Ilyas M Khan, MD

Daniel Morris, APRN, NP-C

M. Musa Khan, MD

Chelsea Slovacek, APRN, NP-C

Venkata Kovvali, MD

Yugandhar Manda, MD

Cheriparambil K. Mani, MD

Vivek Menon, MD

Harshil Patel, MD

Subramanya Venkata, MD

George Vettiankal, MD



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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: _____



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Medical Records Release Form

To: _____
Doctor or Hospital

Address

I hereby authorize and request you to release to:

Name: _____

Address: _____

Phone: _____ Fax: _____

The complete medical records in you possession concerning my illness and/or treatment:

Records Requested: _____

Time Period: _____ To: _____

Reason for release: _____

I understand that this authorization authorizes the release if all medical rerecords including psychiatric, alcohol, drug abuse, and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, section408: Public Law 93-282, Section 333: federal Regulation 421 CFR, Part 2. The information provided is confidential and any disclosure by the recipient is prohibited.

Patient or Nearest Relative

Relation to Patient

Witness

Date

Printed name of patient

Patient's date of birth

SSN

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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 in writing 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 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.