WILLOWBROOK
CARDIOVASCULAR ASSOCIATES
POWERED BY USHV

John Isaac, M.D.
Stanley M. Duchman, M.D.
Tapan G. Rami, M.D., F.A.C.C., F.H.R.S.
Weston C. Hickey, M.D., F.A.C.C., F.S.C.A.I.
Joe Fahed, M.D., F.A.C.C., F.H.R.S.

First Name:	MI:	Last Name:	Nickname:
Address:	City:	State:	Zip:
Social Security #:	Marital Status:	Date of Birth:	
Home Phone:	Cell Phone:	Email Address:	
Occupation:	Employer:		
Race:	Ethnicity:	Language:	

Emergency Contact:	
Relationship:	Phone #: (Please specify phone type)

If Married, please complete spouse's information.	If dependent, please fill out complete Parents information
Spouse's/Parent Name:	Employer's Name:
Social Security #:	Mobile Phone #:
Date of Birth:	Home Phone #:

Responsible Party of Policy Holder (Please check One): Self: ______ Spouse: _______ Parent: _______

Primary Insurance	Secondary Insurance:
Insurance Phone #:	Insurance Phone #:
Policy ID #:	Policy ID #:
Group #:	Group #:

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

Will this Claim be covered under worker's compensation? Yes: ______ No: ______

If yes, name and address of company

Phone #:	Treatment Authorized by:

I hereby consent to medical services and treatment from the physicians and staff of Willowbrook Cardiovascular Associates (WCA). I authorize WCA to release all information to consulting physicians and to my insurance company(ies) for processing of my insurance claims. I assign all insurance benefits payable for the services rendered to me or my dependent and authorize direct payment to WCA. I understand that payment for all services is my ultimate responsibility.

Signature of Patient or Responsible Party (Parent/Guardian) and Relationship   Date

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HIPAA DISCLOSURE
ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed of WCA's Notice of Privacy Practices and the complete description of the uses and disclosures of my health information. I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

RELEASE OF INFORMATION AUTHORIZTION

_____ WCA **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone.

_____ WCA **MAY** discuss my healthcare and may discuss and/or make financial arrangement with only the following individuals:

Name:____________________________________Relationship:___________________ Phone: _________________________

Name:____________________________________Relationship:___________________ Phone: _________________________

Name:____________________________________Relationship:___________________ Phone: _________________________

PREFERENCES

I prefer to be contacted in the following manner:

Phone #: ___________________________________ Email*: _________________________________

_______Leave Message with detailed information.
_______Leave Message with contact information only.
_______DO NOT leave a message.

*By asking to be contacted via email, you are aware that we do not, at this time, have a secure email server and are willing to receive communication in this manner.

Signature of Patient or Personal Representative Date

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means for communication among many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A mean by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosers. I understand that I have a right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices; practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

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 and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in the reliance thereon.

I request the following restrictions to the use or disclosure of my medical information:

____

____

____

Accept ☐ Deny ☐

____

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RELEASE OF INFORMATION

Name:			
Address:	City:	State:	Zip:
Social Security #:	Phone:	Date of Birth:	

I hereby authorize Willowbrook Cardiovascular Associates to:	Release to: ________	Receive From: ________		
Name of Person or Organization				
Address				
Phone:	Fax:			
The Medical Records of (Patient's Name):				
For the Date(s) of:				
For the following purpose(s):	Medical: ________	Legal: ________	Insurance: ________	Other: ________

Select Portions		
_____History and Physical	_____Radiology/Imaging Report(s)	_____Cath Lab Report(s) w/ Diagram
_____Discharge Summary	_____Radiology/Imaging Films	_____Labs
_____Consultations	_____Psychiatric Report(s)/Information	_____ALL MEDICAL RECORDS
_____Operative/Procedure Report(s)	_____Pathology	_____Nursing Notes
_____Electrocardiogram (EKG)	_____HIV Test Results	_____MD Progress Notes
_____Holter Monitor Report(s)	_____AIDS Information	_____MD Orders
_____Nuclear Stress Test Report(s)	_____Billing Records	_____Face Sheet
_____Echocardiogram	_____Itemized Bill	_____
_____Other Cardiac Studies	_____Drug/Alcohol Information	_____

This authorization is valid until the 180th day after the date it is signed unless specified in writing, not to be exceeded by 24 months, or unless it is reviewed (except to the extent that the action has been taken in the reliance on it) and it covers only treatments for the dates specified above. I understand that when this information is used in or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recent and longer be protected. I hereby release and hold harmless WCA from all liability and damages resulting from the faithful release of my Protected Health Information.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by Federal Law. If so, Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is no sufficient for this purpose.

Signature of Patient or Responsible Party (Parent/Guardian) and Relationship   Date

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Willowbrook Cardiovascular Associates (WCA)

Practice Financial Policy and Informed Consent

Willowbrook Cardiovascular Associates (WCA) is committed to your treatment being successful. Please understand payment of your bill is your responsibility. To reduce confusion and misunderstanding between our patients and WCA we have adopted the following financial policy, which we require you to read and sign below. Unless prior arrangements have been made, FULL payment is due at the time of service. We accept cash, credit cards and checks.

Regarding Insurances

We have made arrangements with many insurance carriers and other health plans to accept assignment of benefits. WCA will bill those plans with whom agreements have been made. Co-Payments and deductibles are due at the time services are rendered.

Regarding unpaid bills for *any* applicable Co-Payment or deductible, these will not be subject to our policy of furnishing adverse information to consumer reporting agencies regarding amounts owed by the Patient IF the Patient finalizes a payment plan agreement within 10 days of receiving the first statement.

Regarding Medicare

If you have Medicare, the deductible and the 20% Co-Insurance, when applicable, are due at the time services are rendered.

Regarding Uninsured Patients

By law, we cannot charge below the 2011 Medicare allowed rates for services rendered.

WCA reserves the right to charge 12.5% interest on *any* charges not paid by third party payers which are more than 60 days delinquent and to turn over to our collection agency any accounts after 90 days.

When requesting an estimate for charges for a patient not covered by insurance or any government entitlement program or for services not covered by third party payers or for Patients seeking “Out of Network” medical care, please note the following:

a) Charges may vary based on the Patient’s condition and other factors related to the art of practicing medicine.
b) The request can delay the schedule of care;
c) The actual charges may differ from the amount paid by the third-party payer; and
d) The Patient is personally liable for the charges not paid by the health insurance.

Regarding Usual and Customary or Not Covered

Our Practice is committed to providing the best treatment for our Patient’s and we charge what is usual and customary in our area. You are responsible for Payment regardless of any insurance company’s arbitrary determination of usual and customary rates or what is a “non-covered” service. Payment is due upon receipt of a statement from our office.

Regarding Referrals

In the event your insurance company requires a referral from your Primary Care Physician (PCP) and you arrive for your appointment without an authorized referral or an incorrect referral, you will be responsible for the complete charge or you *may* reschedule your appointment.

Regarding Hospital Services

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of statement from our office.

Regarding Minor Patients

For all services rendered to a minor or dependent Patient, WCA will request the Parent and/or Guardian to be responsible for all payments.

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Regarding Medical Records

Medical records coping fees will be charged according to the guidelines mandated by the *State of Texas Health and Safety Code 241.154, Title 22, Part 9, Chapter 165, Rule § 165.2* prior to researching and copying Patient medical records or filling out other personal paperwork for a Patient. If you have any questions about these charges please contact either office: Medical Center 713-791-1978 or Champions 281-890-4848

Flexible Spending Accounts offered through your Employer

As of January 1, 2011, should you need physicians' prescription for Over-The-Counter medications to satisfy your Flexible Spending Obligations, please request them at the time services are rendered. Call in requests will not be honored.

Regarding Bills and/or Statements

Any questions regarding charges incurred at Willowbrook Cardiovascular Associates (WCA) should be directed to our billing department at 281-943-2800.

Financial Policy

I have read and understand the Financial Policy of WCA and I agree to be bound by its terms. I understand that such terms may be amended from time to time by the Practice.

Informed Consent

I have reviewed the Registration Summary and corrected/updated information where appropriate. I hereby consent to medical services and treatment from physicians and staff of WCA and authorize WCA to all information to consulting physicians and insurance companies for claims processing.

____

Please PRINT name of Patient or Responsible Party (Parent/Guardian) for Patient   Relationship to Patient

____

Signature of Patient or Responsible Party (Parent/Guardian)   Date

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Health Information Pricing Sheet

Effective Immediately: If you require surgical clearance to manage your pacemaker, defibrillator or blood thinner around the time of surgery we will review your medical records, however we can only clear you depending upon your last office visit and studies done at that time. If not, you may be charged a fee of $50.00 for creating, editing and the physician's review of the document without an office visit.

If it's only regarding blood thinners, cessation and resumption, there will be a $25.00 charge.

Cardiac Clearance:
Not seen in the last 30 days
- $50

NOAC Clearance:
- Dental Clearance $25
- Cataract $25

Medication Refills by phone: (One or multiple scripts)
- $20

Forms:
- Disability
  - $50
- Federal Aviation Administration (FAA)
  - $250
- Family and Medical Leave Act (FMLA)
  - $50
- Parking Placard (Our primary patient's Only)
  - $25

Records:
- $25 for the first 20 pages and $0.50 for each additional page thereafter.
- If the document requested needs to be notarized an additional $15 will be charged.

Echo Tapes:
- Per Test
  - $35

Nuclear Pictures:
- Per Test
  - $50

____
Print Patient Name

____
Signature of Patient or Responsible Party (Parent/Guardian) Date

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CALLS AFTER HOURS

Effective immediately: Any calls made to the answering service during non-business hours that require the on-call physician to be paged for after-hours consultation, MAY INCUR A TELEPHONE CONSULTATION FEE OF UP TO $50 DEPENDING ON THE TIME OF CALL, DURATION AND COMPLEXITY OF THE CONSULTATION. THIS WILL INCLUDE MEDICATION REFILLS AND GENERAL MEDICAL QUESTIONS. PLEASE SEE BELOW THE TYPES OF CALLS THAT WILL NOT BE CHARGED AFTER HOURS AND ON WEEKENDS.

Please note, these AFTER-HOURS consultations are typically NOT covered by your insurance company/MEDICARE and therefore will be your financial obligation. The answering service has clear instructions to ask if you accept this fee prior to paging the physician for your consultation and it is your choice to accept the fee and consult the after-hours on-call doctor or to decline the fee and call during regular business hours.

CALLS MADE RELATED TO A RECENT OPERATION OR PROCEDURE WHEREIN THERE IS CONCERN ABOUT A POST PROCEDURE COMPLICATION IS NOT SUBJECTED TO THE FEE.

CALLS REGARDING A PROCEDURE SCHEDULED FOR EARLY (1ST CASE) THE NEXT MORNING ARE NOT SUBJECTED TO THE FEE.

ALL OTHER CALLS MAY INCUR THE AFTER-HOURS CONSULTATION FEE. YOU MAY BE CONTACTED THE NEXT BUSINESS DAY FOR BILLING INFORMATION.

ANY QUESTIONS REGARDING THIS POLICY CAN BE ADDRESSED TO DR. NASIR, DR. RAMI, OR DR. FAHED.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE REVIEWED AND AGREE TO COMPLY WITH THE POLICY ABOVE. FURTHERMORE, I AGREE TO BE FINANCIALLY RESPOSIBLE FOR ANY FEES I MAY INCUR BY CONSULTING THE PHYSICIAN AFTER-HOURS AS STATED ABOVE.

____
PRINT PATIENT NAME

____ ______________________________
PATIENT SIGNATURE/LEGAL REPRESENTATIVE DATE

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Patient Name: ________________________________ Date: ____________

Patient DOB: __________________________________

LOCAL PHARMACY INFORMATION

Pharmacy Name: ____

Address: ____

City/State/Zip: ____

Phone: __________________________ Fax: ________________________

MAIL ORDER PHARMACY INFORMATION

Pharmacy Name: ____

Address: ____

City/State/Zip: ____

Phone: ________________________ Fax: __________________________

Identification Number: ____

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Name:		
DOB:	Height:	Weight:
Reason for your visit:		
Referring physician:		
How did you hear about our office?		

ALLERGIES			
Please describe any allergies to MEDICATIONS, FOOD or Other products:			
Allergy to Iodine/ Contrast	Yes	No	If yes, what type of reaction?

Personal Habits			
Do you smoke now?	Yes No	Do you drink alcohol?	Yes No
What yr did you start?		If so how many per wk /day?	
How many packs / day?		Do you currently exercise?	
Did you smoke in the past?	Yes No	If so how often per wk?	
What yr did you stop?		What type of exercise?	

Family History- If yes, please list the age and relationship of the family member to you		
Do you have a family history of sudden death?	Yes No	
If so who and at what age?		
Male family member w/ heart disease before the age of 55yo	Yes No	
Female family member w/ heart disease before the age of 65yo	Yes No	

Medical History Do you have a history of the following medical problems?					
High blood pressure	Yes	No	Stroke	Yes	No
Prior heart attack	Yes	No	TIA or “mini stroke”	Yes	No
Abnormal ekg	Yes	No	Diabetes	Yes	No
Prior Bypass surgery	Yes	No	Elevated cholesterol or on treatment	Yes	No
Prior Cardiac or Leg Stent	Yes	No	COPD	Yes	No
Heart Valve Disorder	Yes	No	Asthma	Yes	No
Atrial fibrillation	Yes	No	Sleep Apnea	Yes	No
Heart rhythm disorder	Yes	No	Bronchitis	Yes	No
Blood clot in legs/ lung	Yes	No	Arthritis	Yes	No
Peripheral vascular disease	Yes	No	Hx of bleeding in stomach/colon	Yes	No
Poor circulation to legs	Yes	No	Radiation or surgery involving the chest	Yes	No
Aneurysm	Yes	No	Cancer or hx of cancer	Yes	No
Pacemaker or Defibrillator implant	Yes	No	If so, what company/ brand?		

Have you recently (within the last 90 days) experienced any of the following?

GENERAL					
Fever	Yes	No	Fatigue/ weakness	Yes	No
Chills	Yes	No	Sleep disorder	Yes	No
Sweats	Yes	No	Loss of appetite	Yes	No
Wt loss/ wt gain	Yes	No			
EYES/ENT					
Blurred vision	Yes	No	Ringing in your ears	Yes	No
Vision loss	Yes	No	Nosebleeds	Yes	No
Eye irritation	Yes	No	Sore throat	Yes	No
Problems with Anesthesia	Yes	No	Hoarseness	Yes	No
CARDIOVASCULAR					
Chest pain	Yes	No	Shortness of breath with activity	Yes	No
Palpitations	Yes	No	Trouble breathing @night	Yes	No
Passing out	Yes	No	Swelling in ankles/hands	Yes	No
Near passing out	Yes	No	Sleep on multiple pillows	Yes	No
RESPIRATORY					
Cough	Yes	No	Chest pain with deep breath	Yes	No
Shortness of breath @ rest	Yes	No	Excessive sputum	Yes	No
Bloody sputum	Yes	No	Wheezing	Yes	No
GASTROINTESTINAL					
Nausea	Yes	No			
Vomiting	Yes	No	Dark or bloody stools	Yes	No
Diarrhea	Yes	No	Indigestion/ heartburn	Yes	No
Constipation	Yes	No	Difficulty swallowing	Yes	No
GENITOURINARY					
Burning w/ urination	Yes	No	Vaginal bleeding	Yes	No
Blood in urine	Yes	No	Erectile dysfunction	Yes	No
Incontinence	Yes	No	Decreased Libido	Yes	No
Prostate problems	Yes	No	Difficulty with urination	Yes	No
MUSCULOSKELETAL					
Back pain	Yes	No	Leg pain with activity	Yes	No
Joint pain	Yes	No	Restless legs	Yes	No
Muscle weakness	Yes	No	Stiffness	Yes	No
DERMATOLOGY					
Rash	Yes	No	Non healing wounds	Yes	No
Suspicious lesions	Yes	No			
NEUROLOGICAL					
Paralysis	Yes	No	Vertigo	Yes	No
Burning in hands /feet	Yes	No	Frequent falls	Yes	No
Numbness in hands/ feet	Yes	No	Difficulty walking	Yes	No
Tremors	Yes	No	Seizures	Yes	No
PSYCHIATRIC					
Depression	Yes	No	Confusion	Yes	No
Anxiety	Yes	No	Suicidal ideation	Yes	No
Memory loss	Yes	No	Hallucinations	Yes	No

ENDOCRINE					
Cold Intolerance	Yes	No	Increase thirst	Yes	No
Heat intolerance	Yes	No	Unusual wt changes	Yes	No
Increased hunger	Yes	No	Hair loss	Yes	No
HEMATOLOGY					
Abnormal bruising	Yes	No	Enlarged lymph nodes	Yes	No
Bleeding	Yes	No	Blood Clots in leg/arm	Yes	No
ALLERY/ IMMUNOLOGY					
Hives	Yes	No	Hay fever	Yes	No
Allergic rash	Yes	No	Recurrent infections	Yes	No

HOSPITALIZATIONS in the past 6 months-Please include the dates, hospital, and physician's name

SURGERIES-Please include the dates, hospital and surgeon's name

CURRENT MEDICATIONS			
Medication	Dosage	Frequency	Year Started

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FOR OUR PATIENTS

Please take note of the following information to assist our team in providing quality care.

FOR EMERGENT SITUATIONS, CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM.

OFFICE VISIT FOLLOW-UP INSTRUCTIONS

MEDICATIONS
Please bring ALL medications you are currently taking in their original bottle or please bring a current medication list with you to EVERY VISIT. If you bring a medication list, please include the drug name, the dosage amount; the number of times per day you take the medication and the name of the physician who prescribed it.

REFILL REQUESTS
Please request all refills during your office visit when possible. For future refill requests, please contact your pharmacy and request that a refill request be faxed to our office at (713) 791-1870. Please allow 3 business days to process the request. **IN MOST CASES, WE WILL ONLY APPROVE MEDICATIONS THAT DR. NASIR, DR. RAMI, or DR. FAHED PRESCRIBED. A $20 fee will be incurred if you do not get your refills at the time of visit.**

LOST PRESCRIPTIONS
In the event you lose your prescription, or you require an additional medication it will usually require a follow-up visit to our office.

MEDICAL RECORDS / PREVIOUS OUTSIDE TESTING
If you have had any cardiac testing (i.e. EKG's, echocardiogram, stress test, cat scan's) or blood work performed by another physician and the results are important to your ongoing care, **please bring a copy of those records with you** to your visit. The purpose is to avoid delays during your visit with the physician, as we will need to request medical records that are an important part of the decision-making process for your visit. You may be required to reschedule your visit until the necessary information can be obtained.

CALLS TO THE OFFICE

CALL (713) 791-1978 (Please follow the following prompts)

For Dr. Nasir, Dr. Rami or Dr. Fahed, Press 1 *(then select from the prompts)*
Press 1 : FOR PHYSICIAN'S/HOSPITALS ONLY
Press 2 : For Appointments
Press 3 : For Medical Records
Press 4 : For Refills
Press 5 : To speak to a NURSE. *(After pressing 5, select from the available options)*
- Press 1: For Pacemaker, Defibrillator and Reveal Device download or questions.
- Press 2: For Hospital Procedures
- Press 3: For Nurse Questions
- Press 4: Immediate Assistance
- Press 6: For Billing Questions
- Press 7: For Company Information
- Press 0: For the Operator

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Please Keep for your Records

Cardiac Clearance:
Not seen in the last 30 days
- $50

NOAC Clearance:
- Dental Clearance $25
- Cataract $25

Medication Refills by phone: (One or multiple scripts)
- $20

Forms:
- Disability
  - $50
- Federal Aviation Administration (FAA)
  - $250
- Family and Medical Leave Act (FMLA)
  - $50
- Parking Placard (Our primary patient's Only)
  - $25

Records:
- $25 for the first 20 pages and $0.50 for each additional page thereafter.
- If the document requested needs to be notarized or an Affidavit is requested an additional $15 will be charged.
  - Per the Guidelines set by the State of Texas
    - *State of Texas Health and Safety Code 241.154, Title 22, Part 9, Chapter 165, Rule § 165.2*
  - Section E, Subsection 1, Subsection B. (For Medical Records Charges)
  - Section E, Subsection 4, Subsection A. (For Affidavit Charges)

Echo CD/Tapes:
- Per Test
  - $35

Nuclear Pictures:
- Per Test
  - $50