TEXAS INSTITUTE OF CARDIOLOGY, P.A.

FAISAL WAHID, M.D., F.A.C.C., F.S.C.A.I

5313 WEST UNIVERSITY DRIVE

MCKINNEY, TEXAS 75069

PH: (214) 544-7555 FAX: (214) 544-7556

info@ticardiology.com www.ticardiology.com

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	Former name?	Social Security No:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no:	Cell phone No:

City:	State:	ZIP Code:

Employer/Occupation:	Email Address:	Primary Language:

Referring Physician:

Primary Care Physician: Phone #:

INSURANCE INFORMATION

(Please give your insurance card and driver's license to the receptionist.)

Person responsible for bill:

Relationship:	Birth date: / /	Address (if different):	Home phone no.: ( )

Primary Insurance	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

TEXAS INSTITUTE OF CARDIOLOGY PATIENTS MEDICATION NOTICE:

Dr. Wahid requests that every patient seen in the office MUST HAVE medications with them in the BOTTLES (not a list) EVERY visit! Your chart is updated during every visit regardless of any changes. This ensures the best possible care for our patients. If the bottles are not brought and unattainable before the appointment time, your appointment WILL be rescheduled.

Thank you for your cooperation.

Faisal Wahid

I acknowledge understanding of this office policy and agree to abide by it.

Patient Name: _____ Date: _____

***Patient Signature: _____**

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Dear Patient,

Please let us know who we may share your information with:

(If you would like to add additional contacts (other than the patient or legal guardian) that Texas Institute of Cardiology is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like Texas Institute of Cardiology to list as your ***Emergency Contact*** in the event an emergency situation was to take place at our office.)

Contact Name	Relationship to Patient	Contact Phone Number
☐ Billing Account Information	☐ Medical Condition Information	☐ Emergency Contact
Contact Name	Relationship to Patient	Contact Phone Number
☐ Billing Account Information	☐ Medical Condition Information	☐ Emergency Contact
Contact Name	Relationship to Patient	Contact Phone Number
☐ Billing Account Information	☐ Medical Condition Information	☐ Emergency Contact

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's ***Billing Account*** and ***Medical Conditions*** to the patient or legal guardian.
The duration of this authorization indefinite unless otherwise revoked in writing. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

***Patient Signature:** _____

Acknowledgement of The Receipt of Texas Institute of Cardiology (TIC) Notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIIPPA) is a federal government of regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

TIC will furnish you with a notice (by request only) which provides information about how TIC may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have been informed /offered a copy of TIC's Notice of Health Information Practices.**

***Patient Signature:** _____

Please note that we charge $20 for FMLA or disability paper work to be filled out and signed by the doctor.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Texas Institute of Cardiology or insurance company to release any information required to process my claims.

Printed Patient Name: _____ **Date:** _____

***Patient Signature:** _____

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Authorization to Release Health Care Information

Name: _____ **Date of Birth:** _____

We will not disclose your Medical information for any purpose except for treatment, payment and healthcare operations. Any specific written authorization you provide may be revoked at any time by writing us. I am confirming my authorization for use and/ or disclosure of the protected health information described in this form with the people and/ or organizations named in this form.

_____ _____
*Patient/Guardian Signature Date

_____ _____
Name if not patient Relationship to Patient

(FOR OFFICE USE)

I authorize:

Doctor Name:_____
Address:_____
City/State/Zip:_____
Phone:_____
Fax:_____

To release my medical records including any medical history, lab reports, cardiac reports, and any other material regarding medical consultations and treatments to:

Texas Institute of Cardiology
5313 West University Dr
McKinney, TX 75071
PH: 214-544-7555 FX: 214-544-6769

During dates:

_____ to _____

TEXAS INSTITUTE OF CARDIOLOGY

Financial Policy

We would like to thank you for choosing the Texas Institute of Cardiology as your healthcare provider. We are committed to providing our patients with the best possible medical care. The following information outlines your financial responsibilities related to payment for professional services.

As a courtesy, the Texas Institute of Cardiology verifies your benefits with your insurance company prior to your appointment. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. If you do not carry insurance full payment is still expected at the time of service.

It is the policy of the Texas Institute of Cardiology that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

It is the patient's responsibility to provide all necessary insurance information before leaving the office. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage. Returned checks will incur a $30 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our office. Stop payments constitute a break of payment and are subject to the $30 service fee and collections action.

If you have a balance with our office, all treatment, including prescription refills, will be suspended until a payment arrangement is set up.

Our office manager will be happy to answer any questions or concerns you may have.

I understand that I am financially responsible to the Texas Institute of Cardiology for charges not covered by my insurance benefits.

_____ _____

Patient Signature Date

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WWW.TICARDIOLOGY.COM

Texas Institute of Cardiology, PA is charging a $25.00 fee for all paperwork that needs to be completed by our office. This fee is the patient's responsibility, not the insurance's responsibility, and will be due at the time when the paperwork is completed or when the paperwork is dropped off. This includes, but is not limited to, FMLA, Disability paperwork (short term & long term), Parking Permit paperwork, and anything else that needs to be filled out by our Physician, his Medical Assistant, or Office Manager.

I, _____, understand that there is a fee for FMLA/Disability/Parking Plaques/Paperwork of $25.00. This is my responsibility, and I understand that insurance does not cover this cost. I will submit payment at the time services are rendered.

Signature: _____ **Date:** _____
Patient Signature

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Patient Name: **Date:**

SYMPTOMS/REASON FOR VISIT:

MEDICAL PROBLEMS (PLEASE CHECK ALL THAT APPLY)

	CONDITION	YEAR		CONDITION	YEAR
	Angina			Colitis	
	Coronary Artery Disease			GERD	
	Heart Attack			Stomach Ulcer	
	Heart Failure (CHF)			Liver Disease	
	Heart Valve Disease/Type:			Renal Insufficiency/Kidney Disease/Dialysis	
	Bypass Surgery			Gout	
	Angioplasty			Arthritis	
	Peripheral Vascular Disease			Migraine Headaches	
	Irregular Heart Rhythm/Type:			Cancer/Type:	
	High Cholesterol			Stroke	
	High Blood Pressure			Anemia	
	Thyroid Disease: Hyper Hypo			Bleeding/Clotting Disorder	
	Diabetes: Type I Type II			Seizures	
	Sleep Apnea			AIDS/HIV	
	Tuberculosis			Depression/Anxiety	
	Asthma			Bipolar Disorder	
	Lung Disease (COPD)			Other	

PREVIOUS MEDICAL HISTORY

Type and Place of Surgery/Hospitalization	YEAR

PHYSICIANS YOU FOLLOW WITH AND FOR WHAT REASON

Patient Name:	
SOCIAL HISTORY	
Do you exercise Regularly?	**Type of Exercise:** **How often?**
TOBACCO USE (Cigarettes, cigars, pipes, smokeless tobacco, ecigs): **Never I quit (Year:) I still smoke ( ) Packs a day ( ) How long do/did you smoke ( )** **Smokeless Tobacco Number of cans ( ) How long ( )**	
ALCOHOL USE	
How often do you drink: Never Occasionally Socially Daily Weekly **Number of drinks per week ( ) Beer Red Wine White Wine Liquor**	
ALLERGIES (List all medication or food allergies, as well as your reaction):	

FAMILY MEDICAL HISTORY

	Age	Medical Condition	Live/Died	Cause
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brothers				
Sisters				
Sons				
Daughters				