Cardiovascular Wellness Center of Texas

Website: cvwellnesscenter.com
Phone: (903) 892-2030 Sherman
Phone: (214) 491-6365 McKinney
Fax: (903) 892-2004

REGISTRATION FORM

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ S.S. NUMBER: _____

ADDRESS:

_____

CITY: _____ STATE: _____ ZIPCODE: _____

PHONE: _____

ALT. NUMBER: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

REASON FOR VISIT: _____

_____

PRIMARY PHYSICIAN: _____

PHONE: _____

FAX: _____

WHO REFERRED YOU HERE: _____

IN CASE OF AN EMERGENCY NOTIFY: _____

RELATIONSHIP: _____ PHONE: _____

MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

1. Please check all that apply to you past or present.

- ☐ Heart Attack –When? _____
- ☐ Stroke –When? _____
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Issues
- ☐ Leg Pain or Ulcers –Burning? _____ Cramping? _____
- ☐ Lung Disease (Asthma/ Bronchitis/ Emphysema)
- ☐ Pacemaker/Defibrillator

2. Do you have now or have you had in the past, any significant medical illnesses?

Give approximated dates. (Include allergies, anemia, arthritis, bleeding problems, gallbladder disease, and gout.)

_____

_____

_____

3. Please list any surgeries in the past with approximate dates of the procedure and where.

_____

_____

_____

MEDICATION LIST

4. Please list all medications you are currently taking.

Medication Name and Dosage:	**Directions:**

Allergies and Reactions: _____

Pharmacy: _____

Phone Number: _____

Address: _____

5. Social History (Circle Yes or No)

- Do you smoke? Yes or No
- Did you previously smoke? Yes or No When did you stop? _____
- Do you use smokeless tobacco? Yes or No
- Do you drink alcoholic beverages? Yes or No

  If yes how much do you usually drink? (How many daily/weekly)

  _____

6. Family History

Please list each family member, whether living or deceased. List age at time of death if deceased. Also list any known illnesses and or/cause of death.

Family Member	(Circle One)	Age	Illness/Cause of Death
Mother	Living or Deceased	_____	_____
Father	Living or Deceased	_____	_____
Brother(s)	Living or Deceased	_____	_____
	Living or Deceased	_____	_____
Sister(s)	Living or Deceased	_____	_____
	Living or Deceased	_____	_____
Children	Living or Deceased	_____	_____
	Living or Deceased	_____	_____

7. Have you previously had any of the following diagnostic tests? If yes please indicate approximate date, name of physician, and hospital/clinic where performed.

Exercise Treadmill Test/ Chemical Stress Test:

_____

_____

Holter Monitor or Event Recorder:

_____

_____

Cardiac Catheterization / Other Diagnostic Procedure:

_____

_____

Coronary Angioplasty or Stent Placement:

_____

_____

Have you previously been under the care of another cardiologist? Please state name and telephone of previous cardiologist.

_____

_____

No Show and Late Cancellation Policy

All appointments must be cancelled **24 HOURS** in advance. A 'NO SHOW' charge of **$35.00** will be added to your account if you do not show up or cancel the day of your appointment. Emergent cases may be discussed at the following appointment with Dr. Karim. Thank you for your consideration!

_____

Patient Signature

Patient Portal

Our office uses IPatientCare Electronic Medical Record system. This system will help us to provide even better care and improve patient satisfaction. One feature is a Patient Portal that allows for secure communication between our office and you the patient. It also allows us to deliver secure documents (such as lab results) to you at your request.

Please provide an email address so that we can send you a username and activation code directly to your personal email. Once you receive the Patient Portal link, please activate the account. If you experience problems call the office at (903) 892-2030 for assistance.

Email: _____

Signature: _____

I do NOT want to access the patient portal

Opt Out: ☐ Printed Name_____

To opt out of using your patient portal please check the opt out box and print your name.

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300 N. Highland, Suite 365
Sherman, TX 75092
(903) 892-2030
Fax: 855-373-0004
4510 Medical Center Drive, Suite 204
McKinney, TX 75069
(214) 491-6365

NOTIFICATION OF PRIVACY PRACTICES

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purpose and evaluation of the quality of care that you receive. Under some circumstances, we may be *required to use or disclose the information even without your permission.*

Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operation: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purpose:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, disease, information related to recalls of dangerous products, and similar information to public health authorities.
Health over sight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

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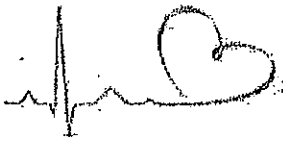
In any other situation we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Electronic Records: You have the right to request a login and password to your electronic health record maintained by the practice. All your records can be accessed online via the login portal.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

M. Asad Karim, MD
Chief, HIPPA Compliance Officer



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Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's **Notice of Privacy Practices.** I understand if I have questions or complaints regarding my privacy rights that I may contact the person listed on such privacy practices. I further understand that the practice will offer me updates to this **Notice of Privacy Practices** should it be amended, modified or changed in any way.

_____ (Sign) _____(Date)

PATIENT AUTHORIZATION

TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize M. Asad Karim's office and its employees to use and/or disclose my protected health information as specified in this request.

Protected Health Information to be Disclosed and Purpose of Disclosure

I authorize **M. Asad Karim's** to disclose my complete patient file, which may include but is not limited to the information described below, to any specialist[s] recommended by **M. Asad Karim's** for the purpose of potential involvement by such specialist(s) in my diagnosis and recommended treatment, if any.

- Test results
- Patient demographic information (such as name, address, phone number)
- Medical Notes/Records/Summary

I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the person or party receiving it; in that case, the information may no longer be protected under federal privacy law.

Notice to the Patient

- You may request a copy of the protected health information to be used or disclosed;
- This authorization only covers PHI that is used or disclosed by <name of dental practice>. The information could be re-disclosed by the person(s) who receive it and, in that case, your PHI will not be protected by the HIPAA privacy and security rules;
- You have the right to revoke this authorization at any time, provided that you do so in writing by submitting the Patient Revocation to **M. Asad Karim's office,** except to the extent that we have already relied on this authorization to use or disclose your information; and
- You may refuse to sign this authorization.

Patient's Information

Patient's Name

_____ (PRINT)

First Name *Middle Name* *Last Name*

_____ (SIGN)

Authorization to release information/assignment of Medicare and Insurance Carrier Benefits

I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or other insurance company claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Furthermore, I request that payments under the medical insurance benefits either to me or to the party who accepts assignment below. Furthermore, I request that payment under medical insurance program be made to

M. Asad Karim, MD PA, Cardiovascular Wellness Center of Texas

I certify that 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 **Cardiovascular Wellness Center of Texas** or **Medicare** or any other **insurance company** to release any information required processing my claims.

PATIENT/ GUARDIAN SIGNATURE: _____

DATE: _____