

**For Office Use Only**  
 Verified Date: \_\_\_\_\_  
 By: \_\_\_\_\_  
 System Account#: \_\_\_\_\_  
 Date/By: \_\_\_\_\_



How did you hear about HeartPlace?

- Physician Referral     Advertisement  
 Friend     Other: Please Specify \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_ last first middle    Doctor: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_    Email Address: \_\_\_\_\_  
 Address: \_\_\_\_\_    City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Ph.: (\_\_\_\_) \_\_\_\_\_ Business Ph.: (\_\_\_\_) \_\_\_\_\_ Cell Ph.: (\_\_\_\_) \_\_\_\_\_  
 Married     Single     Widow     Divorced    Age: \_\_\_\_\_    Date of Birth: \_\_\_\_\_     Male     Female  
 Employer Name: \_\_\_\_\_    Employer Address: \_\_\_\_\_  
 Full-Time     Part-Time     Retired     Self-Employed     Student Full-Time     Student Part-Time  
 Referring Physician: \_\_\_\_\_    Referring Physician Ph.: (\_\_\_\_) \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_    Primary Care Physician Ph.: (\_\_\_\_) \_\_\_\_\_

**Insured Name ( If no insurance, responsible party )**

Name: \_\_\_\_\_    Relationship: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_    Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_    City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Ph.: (\_\_\_\_) \_\_\_\_\_ Business Ph.: (\_\_\_\_) \_\_\_\_\_ Cell Ph.: (\_\_\_\_) \_\_\_\_\_  
 Employer Name: \_\_\_\_\_    Employer Address: \_\_\_\_\_

**Notify In Case of Emergency**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Ph.: (\_\_\_\_) \_\_\_\_\_ Business Ph.: (\_\_\_\_) \_\_\_\_\_  
 2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Ph.: (\_\_\_\_) \_\_\_\_\_ Business Ph.: (\_\_\_\_) \_\_\_\_\_

**Insurance Information – Copies of Insurance Cards and Drivers License are Required**

Insurance 1: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 SS#: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Insurance 2: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 SS#: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Authorizations**

For and in consideration of the services rendered by HeartPlace, 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 judgements 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 HeartPlace 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 judgements. 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 \_\_\_\_\_



## HEARTPLACE PATIENT PRIVACY NOTICE SUMMARY

***Protecting your confidential health information is important to us.*** Certain federal law referred to as “HIPAA” protects the confidentiality of your health information (generally referred to as “**Protected Health Information**” or “**PHI**”), and we take it seriously. This summary of our **Notice of Privacy Practices** (“**Notice**” or “**Privacy Notice**”) has been prepared to provide you with a brief description of certain of the key provisions of the Notice regarding how medical and other personal information about you may be used or disclosed, and how you may obtain access to your information and its disclosure. For a more complete description of our privacy practices under HIPAA, please refer to the attached Notice.

### ***What is Protected Health Information (PHI)?***

PHI is information created or received by HeartPlace and transmitted or maintained in written, electronic or any other form, that relates to your past, present or future health condition, the provision of healthcare to you, and/or information about payment for the provision of your healthcare, and, which may identify you or could reasonably be used to identify you.

### ***How may my PHI be used or disclosed?***

HeartPlace may use or disclose your PHI to carry out your ‘**Treatment**’ (provision, coordination or management of your healthcare or related services), ‘**Payment**’ (obtain payment for your healthcare services, including activities that may be required by your insurer(s) to obtain approval for payment), or for other ‘**Health Care Operations**’ (other functions that HeartPlace performs in connection with providing health care, i.e., quality assessments, training of medical students, credentialing, auditing and financial reporting). Use or disclosure of your PHI pursuant to the Notice may include electronic transmittal or disclosure. HeartPlace also sends PHI to a Health Information Exchange (HIE) to allow for information exchange for information that may be relevant to your future care i.e. in an emergency situation participating facilities and physicians can access your information for your treatment. In addition, your prior prescription information will be obtained through SureScripts to assist us in providing you treatment. You can opt out of the HIE and of SureScripts by completing the appropriate forms available when you ask your HeartPlace office staff.

### ***When might HeartPlace use or disclose my PHI without my authorization?***

HeartPlace is not required to obtain your authorization or notify you when it uses or discloses your PHI for your treatment, to obtain payment, or for other health care operations as discussed above. In addition, there are some limited exceptions where the law allows your PHI to be used to promote the Government’s need to ensure a safe and healthy society. In some cases, you may be given an opportunity to agree or object before the use or disclosure of your PHI. In all cases, HeartPlace will make every effort to ensure that it meets necessary prerequisites and will not use or disclose your PHI more than is permitted under the law.

### ***What Are My Rights Under the HIPAA Privacy Standards?***

Patients have certain rights under the HIPAA Privacy Standards, subject to certain limitations:

- You have the right to request restrictions on certain uses and disclosures of your PHI by HeartPlace.
- You have the right to request that we communicate with you in a certain way. We make every effort to honor your reasonable requests for confidential communication.
- You have the right to read, review and receive copies of your health information.
- You have the right to request and obtain an accounting of disclosures HeartPlace has made of your PHI.
- You have the right to request an amendment to your PHI. (*HeartPlace reserves the right to deny requests to amend PHI. For example, if the information is accurate, or if the information was not created or is not maintained by HeartPlace.*)
- You have the right to request a copy of the Privacy Notice.
- You have the right to file a complaint if you believe that HeartPlace has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules.



**HEARTPLACE PRIVACY OFFICER**

HeartPlace has procedures in place for receiving and resolving HIPAA-related complaints, and, handling other HIPAA and PHI requests and concerns. Such issues are handled by the **HeartPlace Privacy Officer**. You may:

- Request additional restrictions for release of your PHI
- Change restrictions/change contact information
- Request an amendment to your health record
- Request copies of the Notice
- Resolve your complaints (*complaints must be directed in writing to the Privacy Officer*).

**Contact the HeartPlace Privacy Officer:**

**By Mail:** HeartPlace, Attn: Privacy Officer, 16980 Dallas Parkway, Suite 200 Dallas, TX 75248

**By Phone:** (972) 391- 1900

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By my signature below, I acknowledge that I have received a copy of the **HeartPlace Notice Privacy Practices**.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Acknowledgement



**RELEASE OF HEALTH INFORMATION**

PRIMARY CARE PHYSICIAN (PCP): \_\_\_\_\_

Address of PCP: \_\_\_\_\_

- HeartPlace **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone, except as permitted by HIPAA and other applicable laws.
- HeartPlace **MAY** discuss my healthcare and **MAY** discuss and/or make financial arrangements with only the following individual immediate family members listed below:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

I understand that if I would like to authorize HeartPlace to disclose my healthcare and/or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards.

\_\_\_\_\_  
Patient Name (Please Print)                      Patient Signature                      Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection.

- No Expiration
- Date of Expiration \_\_\_\_/\_\_\_\_/\_\_\_\_
- Event: ( Describe event upon which this Authorization will expire ) \_\_\_\_\_

**PATIENT CONTACT PREFERENCES**

I prefer to be contacted in the following manner:       Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
 OK to leave message with detailed information  
 OK to leave message with contact number only  
 DO NOT LEAVE MESSAGE

All normal test results will be sent via our **Patient Portal** to **Email**: ( PLEASE PRINT )

\_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Appointment reminders:     Text [ # if different than above ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ]  
 Phone  
 Email



## AUTHORIZATION FOR ACCESS AND USE OF SURESCRIPTS PRESCRIPTION HISTORY

HeartPlace, with your authorization, has the ability to import the last 16 months of your prescription history directly from the Surescripts E-prescribing database. Surescripts is used by most pharmacies and insurance companies to process prescriptions. If you paid cash or did not pickup a prescription, it will not be in the Surescripts database.

**The import of Surescripts prescription history is not required for treatment.** HeartPlace understands there may be situations, prescriptions, and medical history you do not want to share with your physician. Notifying your physician of all your medical history and currently prescribed medications is critical for proper care.

I hereby authorize the use or disclosure of my individually identifiable health information (“Protected Health Information”) as described below in this form (this “Authorization”) by Surescripts and the access and use of that information by HeartPlace, P.A. (“HeartPlace”).

**Patient’s Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Name of organization(s) authorized to access, use or receive the Protected Health Information: **Surescripts and HeartPlace.** Specific description of Protected Health Information to be accessed, used or disclosed: Prescription drug information, including patient medication history data, maintained in the Surescripts electronic prescription data system.

Event on which this Authorization will expire: **One year**

I understand that I may refuse to sign this Authorization, and that my health care treatment will not be conditioned upon signing this form. I also understand that my Protected Health Information is subject to redisclosure to the authorized recipient of the Protected Health Information pursuant to this Authorization. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace or Surescripts took before it received the revocation of this Authorization. I understand that I may see and copy the Protected Health Information described on this Authorization, if I request to do so in writing. I understand that I will receive a copy of this Authorization after I sign it.

Will HeartPlace or any of its providers receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes**\_\_\_ **No** **X**

\_\_\_\_\_  
Signature of individual or individual’s representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of individual’s representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**\* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION \***



www.heartplace.com

## NEW PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ DATE OF VISIT: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

OTHER PHYSICIANS (THAT YOU WISH TO RECEIVE RECORDS): \_\_\_\_\_

### 1. Reason for visit:

- Main complaint or concern (specify): \_\_\_\_\_
- Establish Cardiovascular Care / Risk Assessment

### 2. Care Team – please identify

- a. Primary Care Provider \_\_\_\_\_
- b. Other physicians that need to receive your cardiovascular care records  
\_\_\_\_\_

### 3. Allergies (specify substance and reaction):

\_\_\_\_\_

### 4. Medications (specify dose, frequency; include over-the-counter, supplements)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### 5. Heart/Vascular History: check and if applicable specify date / detail

CONDITION	YES	NO	DATE/DETAIL
High Blood Pressure			
High Cholesterol			
Diabetes			
Congenital Heart Disease (heart defect at birth)			
Rheumatic Fever			

CONDITION	YES	NO	DATE/DETAIL
Coronary Artery Disease (blocked heart artery)			
Myocardial Infarction (heart attack)			
Congestive Heart Failure (weak heart and/or fluid in lungs)			
Valvular Heart Disease (blocked or leaky valves)			
Arrhythmia (ie: afib)			
Cardiac Surgery / Procedure			
Cerebrovascular Disease (stroke, carotid blockage)			
Peripheral Vascular Disease (leg or arm blockage)			
Aneurysm			
Deep Vein Thrombosis / Pulmonary Embolism (leg / lung clots)			
Vascular Surgery / Procedure			

**6. Family History:** do your parents and/or siblings have heart and/or vascular disease? If so please specify the problem and age it started:

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Sibling(s): \_\_\_\_\_

**7. Lifestyle:**

a. **Have you ever smoked?** (if yes, specify how much and for how many long):

\_\_\_\_\_

b. **Do you drink alcohol?** (if yes, specify how much and how frequently):

\_\_\_\_\_

c. **Do you use drugs?** (if yes, specify type and how frequently):

\_\_\_\_\_

8. **Occupation:** \_\_\_\_\_

9. **Marital status:**

- Single  Widowed  
 Married  Divorced

10. **Residence: with whom do you live?**

- Spouse  
 Alone  
 Other (please specify): \_\_\_\_\_

11. **Education Level:** (specify highest level): \_\_\_\_\_

12. **Children:** (specify number, age(s)): \_\_\_\_\_

13. **Surgeries:** (specify prior operations/surgeries with date):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. **Prior Testing:** (if applicable)

Last / Prior Stress Test Date: \_\_\_\_\_  
Last / Prior Echocardiogram (ultrasound) Date: \_\_\_\_\_  
Last / Prior Cardiac Catheterization Date: \_\_\_\_\_

15. **Other Past Medical History:**

Please list **other (non-cardiac/vascular)** medical problems not identified above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**16. Are you experiencing or have you recently experienced any of the following?**

- |   |  |
|---|--|
| <input type="checkbox"/> Activity Change                            | <input type="checkbox"/> Vomiting blood                        |
| <input type="checkbox"/> Fever                                      | <input type="checkbox"/> Blood in the stool                    |
| <input type="checkbox"/> Weight gain                                | <input type="checkbox"/> Acid reflux (heart burn)              |
| <input type="checkbox"/> Weight loss                                | <input type="checkbox"/> Blood in the urine                    |
| <input type="checkbox"/> Vision change                              | <input type="checkbox"/> Difficulty urinating                  |
| <input type="checkbox"/> Snoring                                    | <input type="checkbox"/> Muscle weakness                       |
| <input type="checkbox"/> Room spinning (vertigo)                    | <input type="checkbox"/> Muscle aches                          |
| <input type="checkbox"/> Cough                                      | <input type="checkbox"/> Skin sore or ulcer                    |
| <input type="checkbox"/> Coughing up blood                          | <input type="checkbox"/> Excessive bleeding                    |
| <input type="checkbox"/> Shortness of breath at rest                | <input type="checkbox"/> Excessive bruising                    |
| <input type="checkbox"/> Shortness of breath on exertion            | <input type="checkbox"/> Easy bleeding                         |
| <input type="checkbox"/> Wheezing                                   | <input type="checkbox"/> Temperature intolerance (hot or cold) |
| <input type="checkbox"/> Pain with breathing                        | <input type="checkbox"/> Frequent urination                    |
| <input type="checkbox"/> Chest pain/discomfort                      | <input type="checkbox"/> Excessive thirst                      |
| <input type="checkbox"/> Sweating                                   | <input type="checkbox"/> Tremor(s)                             |
| <input type="checkbox"/> Palpitations (racing/irregular heart beat) | <input type="checkbox"/> Depression                            |
| <input type="checkbox"/> Shortness of breath lying flat             | <input type="checkbox"/> Anxiety                               |
| <input type="checkbox"/> Wake up short of breath                    | <input type="checkbox"/> Increased stress                      |
| <input type="checkbox"/> Passing out / Loss of consciousness        | <input type="checkbox"/> Dizziness                             |
| <input type="checkbox"/> Near passing out / near fainting           | <input type="checkbox"/> Seizures                              |
| <input type="checkbox"/> Leg swelling                               | <input type="checkbox"/> Memory loss                           |
| <input type="checkbox"/> Varicose veins                             | <input type="checkbox"/> Drooping of the face                  |
| <input type="checkbox"/> Pain in the legs                           | <input type="checkbox"/> Difficulty with balance               |
| <input type="checkbox"/> Leg/foot ulcer/wound                       | <input type="checkbox"/> Confusion                             |
|   | <input type="checkbox"/> Paralysis                             |
|   | <input type="checkbox"/> Numbness of limbs                     |
|   | <input type="checkbox"/> Slurred speech                        |



**AUTHORIZATION FOR RELEASE OF INFORMATION TO HEARTPLACE**

TO: \_\_\_\_\_

1. I hereby consent to the release and transfer to:

**HeartPlace**

\_\_\_\_\_  
\_\_\_\_\_

the following information from its records on:

\_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Social Security Number

SPECIFY INFORMATION: \_\_\_\_\_  
\_\_\_\_\_

2. The above information is released for the following purpose and that purpose only. **Other uses are prohibited.**

\_\_\_\_\_

3. I understand that the specific information to be released may include, but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data.

4. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace too, including any uses or disclosures of my Protected Health Information made by HeartPlace, before it received the revocation of this Authorization.

5. I understand that if my Protected Health Information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

6. I understand that I have a right to inspect and copy my own Protected Health Information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

7. I authorize faxing the information to be disclosed to the requesting party  yes  no

8. I have read and understand this consent and I have signed it voluntarily and of my own free will.

9. This authorization will expire ninety (90) days from the date of signature.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Specify relationship (legal & authorization where applicable)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

*Prohibition of Re-disclosure: This information has been disclosed to you from records which are confidential. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.*