WOODLANDS HEART & VASCULAR INSTITUTE

PATIENT REGISTRATION

Email:_____

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)			ADDRESS		
CITY, STATE		ZIP	HOME PHONE	CELL PHONE	
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____		
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE		
INSURED/RESPONSIBLE PARTY INFORMATION		RELATION TO PATIENT: ❑spouse ❑parent ❑guardian			
NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER	
INSURANCE INFORMATION					
PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
PRIMARY DOCTOR/FAMILY DOCTOR		REFFERING DOCTOR			
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP	PHONE NUMBER		

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

920 Medical Plaza Dr., Ste 520
The Woodlands, TX- 77380
Phone: (832) 562-3974 Fax: (832) 663-9378

WOODLANDS HEART & VASCULAR INSTITUTE

AUTHORIZATION TO RELEASE INFORMATION

Authorization to release health information to:			
Name(s)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ☐ NEVER DATE:		

Release the following information:

☐ All Records ☐ Chart Notes ☐ Radiology Reports ☐ Operative Reports ☐ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

*** Preferred Pharmacy:

Allergies

☐ NONE/No Known Allergies ☐ Adhesive Tape ☐ Anesthesia ☐ Aspirin ☐ Codeine
☐ Dairy Products ☐ Iodine/Shellfish/Contrast Dye ☐ Latex ☐ Morphine ☐ Penicillin
☐ Sulfa Drugs ☐ Wheat

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

WOODLANDS HEART & VASCULAR INSTITUTE

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ☐ NONE of the problems listed
- ☐ allergies
- ☐ anemia
- ☐ arthritis conditions
- ☐ asthma
- ☐ arterial fibrillation
- ☐ bleeding problems
- ☐ BPH
- ☐ CAD coronary artery disease
- ☐ cancer
- ☐ cardiac arrest
- ☐ celiac disease
- ☐ chest pain
- ☐ CHF congestive heart failure
- ☐ chronic fatigue syndrome
- ☐ depression
- ☐ diabetes
- ☐ drug/alcohol abuse
- ☐ erectile dysfunction
- ☐ fibromyalgia
- ☐ Gerd
- ☐ heart disease
- ☐ high cholesterol
- ☐ hyperinsulinemia
- ☐ hyperlipidemia
- ☐ hypertension
- ☐ hypogonadism male
- ☐ hypothyroidism
- ☐ infection problems
- ☐ insomnia
- ☐ irritable bowel syndrome
- ☐ kidney problems
- ☐ menopause
- ☐ migraines/headaches
- ☐ neuropathy
- ☐ onychomycosis
- ☐ organ injury
- ☐ osteoporosis
- ☐ pulmonary embolism/blood clot in legs
- ☐ seizure disorders
- ☐ shortness of breath
- ☐ sinus conditions
- ☐ stroke
- ☐ syndrome X
- ☐ tremors
- ☐ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

PATIENT'S PHARMACY PREFERENCE

_____

_____

_____

_____

920 Medical Plaza Dr., Ste 520
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WOODLANDS HEART & VASCULAR INSTITUTE

CONSENTMENT FOR TREATMENT

I voluntarily give my permission to the health care providers of Woodlands Heart & Vascular Institute and such assistants as they may deem necessary to provide medical care services to me. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from Woodlands Heart & Vascular Institute providers, or until I withdraw my consent.

Signature of Patient or Guardian Date

Printed Name of Patient or Guardian Relationship to Patient

A duplicate or faxed copy of this form is considered the same as the original document.

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RESPONSIBLE PARTY

I am responsible for paying all charges on this account, regardless of insurance coverage. I understand that all fees incurred in the office are payable at the time of services. I authorize release of any medical record information for filing claims and/or select records from other physician's care on an as needed basis. I authorize payment of insurance benefits to Woodlands Heart and Vascular Institute, P.A.

24 hour notice is required for all cancellations. In regards to missed appointments a "No Show Fee" charge of **thirty five dollars ($35.00)** will be charged to the patient after the second "No Show". This charge is not billable to the insurance company and therefore, will be due before future services are rendered. After three (3) "No Shows" in a twelve (12) month period the patient may be dismissed from the practice.

A photocopy of this agreement shall be as valid as the original.

_____
Signature of Patient

_____
Date

_____
Other Legally Responsible Party

_____
Reason Patient unable to sign

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WOODLANDS HEART & VASCULAR INSTITUTE

Symptoms: Please mark (X) in the available blanks if any of the following applies to you NOW or in the PAST:

NOW	PAST		NOW	PAST	
		General			**Females**
____	____	Unexplanied fever/night sweats	____	____	Pregnant
____	____	Unexplained weight loss/gain	____	____	Date of last period_____
____	____	Fatigue	____	____	Number of Pregnancies_____
		Head, Eyes, Ears, Nose, Throat	____	____	Live Births_____Abortions_____
____	____	Head Injury/Concussion	____	____	Miscarriages_____Still Births_____
____	____	Draining/painful ears			Menopause Yes____ No____
____	____	Dizziness or loss of balance			**Males**
____	____	Chronic nasal congestion/drainage	____	____	Impotence
____	____	Frequent nose bleeds	____	____	Difficulty getting an erection
____	____	Difficulty swallowing			**Endocrine System**
____	____	Hoarseness	____	____	Dry Skin, cold intolerance
____	____	Throat pain	____	____	Thirst
____	____	Jaw Pain	____	____	Appetite Change
____	____	Snoring/Sleep Apnea			**Heme/Lymph System**
____	____	Double Vision/Eye Pain/Change in Vision	____	____	Easy Bruising
		Lungs	____	____	Bleeding Problems
____	____	Coughing up Blood	____	____	Enlarged Glands
____	____	Persistent Wheezing/Asthma			**Allergy/Immune System**
____	____	Shortness of Breath w/ Exertion	____	____	Hives/Chronic Itching
		Heart-Circulation	____	____	Previous Allergy Workup
____	____	Chest Pain			**Nervous System**
____	____	Heart Palpitations	____	____	Convulsions(seizures, fits, epilepsy)
____	____	Leg Vein Trouble/Pain When Walking	____	____	Tremor (shaking, trembling)
____	____	Ankle Swelling	____	____	Paralysis (or weakness in any body part)
		Stomach-Intestinal	____	____	Numbness(body parts "go to sleep")
		Heartburn/Regurgitation/Indigestion			**Psychological**
____	____	Frequent or Severe Stomach Pain	____	____	Anxiety
____	____	Frequent or Severe Vomiting	____	____	Depression
____	____	Constipation	____	____	Suicidal Thoughts
____	____	Diarrhea			**Skin**
____	____	Rectal Bleeding	____	____	Rash
		Urinary	____	____	Open Wounds
____	____	Frequent Urination/Trouble Holding Urine	____	____	Changes in Nails
____	____	Trouble Starting to Urinate			
____	____	Urinate more that TWO times a night			
____	____	Blood in Urine			

Patient Signature_____ Date: _____

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WOODLANDS HEART & VASCULAR INSTITUTE

PERIPHERAL ARTERIAL DISEASE TEST SURVEY

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____

Date:_____

Mark "Yes" or "No"

	YES	NO	TEST
Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?			*(440.21)*
Do you experience any pain at rest in your lower leg(s) or feet?			*(440.22)*
Do you experience foot or toe pain that often disturbs your sleep?			*(440.22)*
Are your toes or feet pale, discolored, or bluish?			*(440.22)*
Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12weeks)?			*(707.10 – 707.19)*
Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?			*(443.9)*
Have you suffered a severe injury to the leg(s) or feet?			*(904.8)*
Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?			*(440.24)*

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WOODLANDS HEART & VASCULAR INSTITUTE

VEIN SCREENING FORM
Please complete left side of form only.

Date: _____ Appt Time: _____ Screening Provider: _____

Name: _____ Primary Care Physician: _____

DOB: _____ Sex: ☐M ☐F Insurance Provider: _____

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐Y ☐N	Leg:	☐R	☐L
Phlebitis (vein redness/tenderness)	☐Y ☐N	Leg:	☐R	☐L
Blood clots	☐Y ☐N	Leg:	☐R	☐L
Deep vein thrombosis (DVT)	☐Y ☐N	Leg:	☐R	☐L
Saphenous vein reflux	☐Y ☐N	Leg:	☐R	☐L

Do you experience any of the following in your leg(s):

Aching/pain	☐Y ☐N	Leg:	☐R	☐L
Heaviness	☐Y ☐N	Leg:	☐R	☐L
Tiredness/fatigue	☐Y ☐N	Leg:	☐R	☐L
Itching/burning	☐Y ☐N	Leg:	☐R	☐L
Swelling	☐Y ☐N	Leg:	☐R	☐L
Cramps	☐Y ☐N	Leg:	☐R	☐L
Restless legs	☐Y ☐N	Leg:	☐R	☐L
Throbbing	☐Y ☐N	Leg:	☐R	☐L
Skin or ulcer problems	☐Y ☐N	Leg:	☐R	☐L
Other:	☐Y ☐N	Leg:	☐R	☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐Y ☐N	What?	_____
Elevation of legs	☐Y ☐N	What?	_____
Wear support hose	☐Y ☐N	What?	_____

II. Family History

Have any of your family members had:

Varicose veins	☐Y ☐N	Who?	_____
Vein stripping	☐Y ☐N	Who?	_____
Blood coagulation disorder	☐Y ☐N	Who?	_____
Blood clots	☐Y ☐N	Who?	_____
Stroke, heart attacks or pulmonary emboli	☐Y ☐N	Who?	_____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

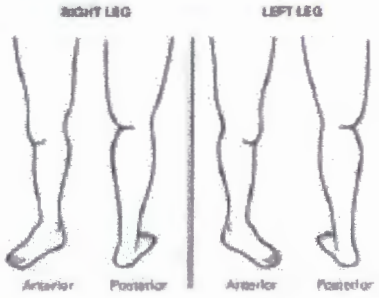
Sclerotherapy	☐Y ☐N	Leg:	☐R	☐L
Laser therapy (spider veins)	☐Y ☐N	Leg:	☐R	☐L
Phlebectomy	☐Y ☐N	Leg:	☐R	☐L
Vein stripping surgery	☐Y ☐N	Leg:	☐R	☐L
RF ablation (VNUS Closure®)	☐Y ☐N	Leg:	☐R	☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐Y ☐N	
Prolonged sitting periods	☐Y ☐N	
Do you exercise regularly?	☐Y ☐N	
Do you smoke?	☐Y ☐N	
Pregnancies	☐Y ☐N	How many? ___

V. Vein Screening (to be completed by screening provider)



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

LEFT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

Clinical Assessment:

☐ Chronic venous insufficiency ☐R ☐L
☐ Other: _____ ☐R ☐L

Treatment Plan:

☐ Duplex ultrasound ☐R ☐L
☐ Sclerotherapy ☐R ☐L
☐ Medical compression stockings ☐R ☐L
☐ Other: _____ ☐R ☐L

Screening Provider Signature: _____

Follow-up Appointment
Date: _____ Time: _____
Physician: _____
Physician Phone Number: _____

NOTES:

WOODLANDS HEART & VASCULAR INSTITUTE

SLEEP APNEA SURVEY

Patient:_____ **Date:**_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading	[ ]
Watching TV	[ ]
Sitting, inactive in a public place (e.g. a theatre or a meeting)	[ ]
As a passenger in a car for an hour without a break	[ ]
Lying down to rest in the afternoon when circumstances permit	[ ]
Sitting and talking to someone	[ ]
Sitting quietly after a lunch without alcohol	[ ]
In a car, while stopped for a few minutes in the traffic	[ ]
Total	[ ]

Score: <10 Normal range, >10 Test for OSA

STOP BANG Questionnaire

STOP

S (snore) Have you been told that you snore? YES / NO

T (tired) Are you often tired during the day? YES / NO

O (obstruction) Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep? YES / NO

P (pressure) Do you have high blood pressure or on medication to control high blood pressure? YES / NO

BANG

B (BMI) Is your body mass index greater than 28? YES / NO

A (age) Are you 50 years old or older? YES / NO

N (neck) Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches. YES / NO

G (gender) Are you a male? YES / NO

Score: Answered yes to three or more items, Test for OSA.

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WOODLANDS HEART & VASCULAR INSTITUTE

Notice of Privacy Practices (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically. Or paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA" we have prepared this explanation of how we required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance for payment.
- Health care operations include business aspects of running our practice. Such as conduction quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treating alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to amend your protected health information
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights about violators of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing complaint. Please contact us for more information: For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

By signing this form you have read and agree to the Health Insurance Portability & Accountability Act of 1996 ("HIPPA")

Patient Signature:_____ Date_____

Witness Signature:_____ Date:_____

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WOODLANDS HEART & VASCULAR INSTITUTE

PATIENT CONFIDENTIALITY

Purpose:

Woodlands Heart & Vascular Institute, P.A. has a legal, ethical, and moral obligation to protect the confidentiality of our patients. Employees will hold all information about any patient strictly confidential. No discussion of patients outside of the patient-care framework will be allowed, and any conversation between staff members that is directed at delivering quality patient care will be held in a confidential and professional manner. As our concern for confidentiality is second only to our concern for quality care, there are a number of policies regarding this topic in this manual. Additional information is included in the **Privacy Basics** section of our manual as well as other sections. The possible employment repercussions of staff violating patient confidentiality also are discussed in this section.

Policy:

- All telephone contacts regarding specific information about a patient will be answered and addressed according to protection under the *Telephone Security Measures* policy and procedure if the caller claims to be a patient, and under the *Third-Party Calls About Patients* policy and procedure if the caller is not a patient.

- All patient records will be secured in the allocated place within this facility. Only appropriate staff members are allowed in areas of the practice containing patient records, and staff members will only access those portions of patient records necessary to do their jobs and/or deliver care.

- Staff will ensure at all times that conversations regarding patients are not overheard by others.

- Any and all information gathered or heard, officially or unofficially, about a patient shall be construed as confidential. Release of any information by an employee to another patient, a fellow employee, or any unauthorized person shall be regarded as a breach of confidence and grounds for disciplinary action, up to and including termination of employment.

- Medical records shall never be left where unauthorized persons can read them.

- Medical records may be reviewed by the patient, by the parent of a minor (under most circumstances), and by anyone who has a legal duty/authority such as a guardian or a person with a legal right under an effective durable power of attorney. Such persons will be asked to sign an appropriate release.