WOODLANDS HEART & VASCULAR INSTITUTE

Woodlands Heart & Vascular Institute, P.A.
920 Medical Plaza Drive, Suite 520
The Woodlands, TX 77380
Office: (832)562-3974 Fax: (281) 771-3542 or (832) 663-9378

Patient Information
Patient Name: Last, First, Middle
Social Security #:
Date of Birth:
Patient Address:
City/State/Zip code:
Cell Phone:
Home Phone:
Work Phone
Email:
Occupation: ☐Full-Time ☐Part-Time ☐ N/A
Employer Name/Occupation:

Primary Insurance Information
INS Carrier: **Policy & Group No:**
Guarantor Name & DOB:
Relationship to Guarantor: ☐Child ☐ Parent ☐Spouse

Person Responsible for bills (if other than patient)
Name:
Address (if different, from patient):
City/State/Zip code:
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Life Partner ☐ other family member
Telephone#:

PRIMARY PHYSICIAN
Name:
Telephone#:

Pharmacy:
Telephone#:
Mail Order pharmacy, if applicable:

Patient Information
Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ other
Race: (for medical purposes-optional) ☐ African American ☐ Asian ☐ American Indian or Alaska Native ☐ White ☐ Decline ☐ Other: _____
Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Decline

Emergency Contact
Name:
Relationship:
Telephone#:

Living Will
Do you have a living will (65 & older)? ☐ Yes ☐ No ☐ N/A

Additional Information
May we call your phone and/or email you: ☐ Yes ☐ No
May we leave a message on your answering machine or email regarding the following: • **Appointment Reminders** • **Asking you to call back?** • **Inform you that a prescription has been called in to your pharmacy?** ☐ Yes ☐ No **May we leave a message with a member (s) of your household?** ☐ Yes ☐ No
Consent for Photo Identification: **I consent to having my picture used in my electronic medical record as a photo ID, to ensure the accuracy of my identity, also my safety.** ☐ Yes ☐ No

REFERRAL SOURCE
How Did you learn of our office?
Patient PRINTED Name:
Signature:
Date:

WOODLANDS HEART & VASCULAR INSTITUTE

PATIENT MEDICAL HISTORY

Patient Name: _____**DOB**: _____ **Date**: _____

What is the reason for today's visit? _____

_____

HISTORY OF PRESENT ILLNESS

Allergies: ☐ NKDA/No Known Allergies. Please list known allergies: _____

_____

_____

PAST MEDICAL HISTORY

Have you EVER had any of the following?

- ☐ NONE- No history
- ☐ Anemia
- ☐ Arthritis conditions
- ☐ Asthma
- ☐ Arterial Fibrillation
- ☐ Bleeding Conditions
- ☐ BPH-Benign prostatic hyperplasia
- ☐ CAD-Coronary Artery Disease
- ☐ Cancer: _____
- ☐ Carotid Artery Disease
- ☐ Cardiac Arrest
- ☐ Cardiomyopathy
- ☐ Celiac Disease
- ☐ Chest Pain
- ☐ CHF-Congestive Heart Failure
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Diabetes (Type I/ II)
- ☐ Drug/Alcohol Abuse
- ☐ Erectile Dysfunction
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hiatal Hernia
- ☐ High Cholesterol
- ☐ Hyperinsulinemia
- ☐ Hyperlipidemia
- ☐ Hypertension (HBP)
- ☐ Hypogonadism male
- ☐ Hypothyroidism
- ☐ Infection Problems
- ☐ Insomnia
- ☐ IBS-Irritable Bowel Syndrome
- ☐ Kidney Problems
- ☐ Menopause
- ☐ Migraines/headaches
- ☐ Neuropathy
- ☐ Onychomycosis
- ☐ Organ Injury
- ☐ Osteoporosis
- ☐ Pain In Legs When Walking
- ☐ PVD (Peripheral Vascular Disease)
- ☐ Pulmonary Embolism/Blood Clots in legs
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Sinus Conditions
- ☐ Stroke
- ☐ Syndrome X
- ☐ Tremors
- ☐ Ulcers
- ☐ Whooping Cough

Have you had any other medical problems diagnosed that we have not asked out? _____

_____

Have you had any of the following medical services?

Holter Monitor	Yes	No	Angioplasty or stent	Yes	No
Stress Test	Yes	No	CABG (Coronary Artery Bypass Surgery)	Yes	No
Echocardiogram	Yes	No	Pacemaker Insertion	Yes	No
Cardiac Catheterization	Yes	No	ICD (Defibrillator Insertion)	Yes	No

MEDICATIONS

PLEASE LIST ALL PRESCRIBED, AND OTC MEDICATIONS INCLUDING VITAMINS & SUPPLEMENTS
PLEASE ATTACH SEPARATE LIST FOR ANY MED LIST WITH 5+ MEDICATIONS

MEDICATION/STRENGTH	DOSAGE	PRESCRIBING DOCTOR

SURGICAL HISTORY

Surgery: _____Date/Year: _____ Dr._____

Surgery: _____Date/Year: _____ Dr._____

Surgery: _____Date/Year: _____ Dr._____

Surgery: _____Date/Year: _____ Dr._____

Surgery: _____Date/Year: _____ Dr._____

SOCIAL HISTORY

Do you drink alcohol? ☐ NO ☐ Yes If so how often: ☐ Daily ☐ Weekly ☐ Social ☐Occasionally

Choice of alcohol: ☐ Beer ☐ Hard Liquor ☐Wine

Do you consume caffeine? ☐ NO ☐ Yes If so how often: 1 2 3 4 5 _____per day

Type: ☐Coffee ☐Tea ☐ Soda ☐Chocolate

Tobacco Use: ☐ Never ☐ NO, ***Former smoker*** Quit Year: _____ ☐ YES

If YES, how many packs/cigarettes/cigars per day or week: ☐ 1/2 pk ☐ 1pk ☐_____

Smokeless Tobacco Type: ☐ Chew ☐ Vape ☐Other_____

Recreational Drug Use: ☐ NO ☐ Yes Type:_____

FAMILY HISTORY

Relationship	Status	Anemia	Arrhythmia	Diabetes	Clotting Disorder	Heart Attack	Heart Disease	High BP	High Cholesterol	Stroke	Cancer
Mother											
Father											
Sister											
Brother											

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SLEEP APNEA SURVEY

Patient Name: _____ DOB: _____ Gender: M F 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 <u>most appropriate</u> number of 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 meeting) …….. (____)
As a passenger in a care 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…….. (____)

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

<u>STOP BANG Questionnaire</u>

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 3 or MORE ITEMS, TEST FOR OSA.

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INDICATION FOR PAD QUESTIONNAIRE

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrow 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 stroke. 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.

(PAD) PERIPHERAL ARTERIAL DISEASE QUESTIONAIRE- ENGLISH

Patient Name: _____ DOB: _____ Gender: M F Date:_____

ANSWERS TO THE FOLLOWING QUESTIONS WILL HELP DETERMINE IF YOU ARE AT RISK FOR PAD, AND IF A COMPREHENSIVE VASCULAR EXAMINATION IS NEEDED.

1. Do you have a skin wound, scab, infection or ulcer on your leg, ankle, or foot That has not healed in 8 or more weeks? ☐ Yes ☐ No
2. Do you have pain in your legs or feet while at rest/sleeping? ☐ Yes ☐ No
3. Do you have pain in your legs or feet that is worsened by activity or exercise, And relieved by rest (i.e. “claudication”)? ☐ Yes ☐ No
4. Do you have a history of kidney disease? ☐ Yes ☐ No
5. Are you over the age of 50 with Diabetes with a history of smoking? ☐ Yes ☐ No
6. Are you over the age of 50 with Diabetes with a history of heart disease? ☐ Yes ☐ No
7. Are you over the age of 50 with Diabetes with a history of Stroke? ☐ Yes ☐ No
8. Are you over the age of 50 with Diabetes with a history of aneurysm? ☐ Yes ☐ No
9. Are you over the age of 50 with Diabetes with a history of peripheral Neuropathy? ☐ Yes ☐ No
10. Are your toes or feet pale, discolored or bluish? ☐ Yes ☐ No
11. Has your doctor ever told you that you have diminished or absent Pedal (foot) pulses? ☐ Yes ☐ No
12. Have you suffered a severe injury to the leg (s) or feet? ☐ Yes ☐ No

WOODLANDS HEART & VASCULAR INSTITUTE

VEIN SCREENING FORM

FILL OUT LEFT SIDE OF FORM ONLY

Patient Name: _____ DOB: _____ Gender: M F Date:_____

I.Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐ Y ☐ N Leg: L ☐ R ☐
Phlebitis	☐ Y ☐ N Leg: L ☐ R ☐
Blood clots	☐ Y ☐ N Leg: L ☐ R ☐
Deep vein thrombosis	☐ Y ☐ N Leg: L ☐ R ☐
DVT	☐ Y ☐ N Leg: L ☐ R ☐
Saphenous vein reflux	☐ Y ☐ N Leg: L ☐ R ☐

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

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

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

Medication for pain	☐ Y ☐ N Leg: L ☐ R ☐
Elevation of legs	☐ Y ☐ N Leg: L ☐ R ☐
Wear support hose	☐ Y ☐ N Leg: L ☐ R ☐

II. Family History

Have any of your family members had:

Varicose veins	☐ Y ☐ N Leg: L ☐ R ☐
Vein stripping	☐ Y ☐ N Leg: L ☐ R ☐
Blood coagulation disorder	☐ Y ☐ N Leg: L ☐ R ☐
Blood clots	☐ Y ☐ N Leg: L ☐ R ☐
Stroke, heart attacks or Pulmonary emboli	☐ Y ☐ N Leg: L ☐ R ☐

III.Vein Treatment History

Have you ever been treated for varicose veins with:

Sclerostherapy	☐ Y ☐ N Leg: L ☐ R ☐
Laser therapy (spider veins)	☐ Y ☐ N Leg: L ☐ R ☐
PhlebectomyVein stripping surgery	☐ Y ☐ N Leg: L ☐ R ☐
RF ablation (VNUS Closure)	☐ Y ☐ N Leg: L ☐ R ☐

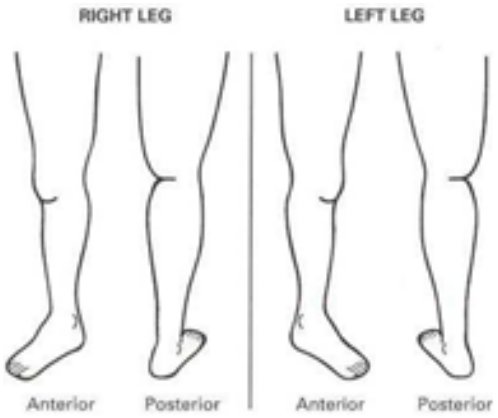
IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐ Y ☐ N
Prolonged sitting periods	☐ Y ☐ N
Do you exercise regulary?	☐ Y ☐ N
Do you smoke?	☐ Y ☐ N
Pregnancies	☐ Y ☐ N How many? ____

V. Vein Screening (to be completed by 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 Ulcer

LEFT LEG (Check all that apply)

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

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:_____

WOODLANDS HEART & VASCULAR INSTITUTE

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Please circle your answer)

Name: _____ Date: _____

	Not at all	***Several days***	***More than half the days***	***Nearly every day***
Little interest or pleasure in doing things	0	*1*	*2*	*3*
Feeling down, depressed, or hopeless	0	*1*	*2*	*3*
Trouble falling or staying asleep, or sleeping too much	0	*1*	*2*	*3*
Feeling tired or having little energy	0	*1*	*2*	*3*
Poor appetite or overeating	0	*1*	*2*	*3*
Feeling bad about yourself-or that you're a failure or have let yourself or your family down.	0	*1*	*2*	*3*
Trouble concentrating on things	0	*1*	*2*	*3*
Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	*1*	*2*	*3*
Thoughts that you would be better off dead or hurting yourself in some way	0	*1*	*2*	*3*

FOR OFFICE CODING _____+_____+_____+_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	*Somewhat difficult*	*Very difficult*	*Extremely difficult*
☐	☐	☐	☐

WOODLANDS HEART & VASCULAR INSTITUTE

OFFICE POLICIES AND PROCEDURES

Thank you for choosing Woodlands Heart and Vascular Institute for your cardiovascular care.

The staff at Woodlands Heart and Vascular Institute strives to exceed your expectations in order to make your experience with us comfortable and stress free. Please feel free to contact our office if you have any questions concerning our policies.

OFFICE HOURS Our office staff is available Monday-Thursday, 8:00 am to 5:00 pm and Friday 8 am to 3 pm, excluding holidays, and may be reached at (832)562-3974 for routine matters such as appointment scheduling, prescription refills, and other nonemergency matters. An answering service is available to assist you after scheduled office hours. In the event of a medical emergency, please call 911. Our staff will always assist you to the best of their abilities during office hours. If your matter requires a return call from Dr. Fernandes, or the nursing staff, please allow 24 hours to receive a return call.

APPOINTMENTS When calling for an appointment, please be prepared to provide our staff with your chief complaint and reason for the visit, as well as any updated contact or insurance information. While we strive to see each patient that is scheduled within a reasonable amount of time emergencies can occur in specialty medicine and Dr. Fernandes will always give each of his patients the time they require for their unique medical problem. For this reason, we kindly request your patience and understanding should a delay occur, or rescheduling be necessary, on your appointment date. **It is the policy of this office that cancellations must be made within 24/48 hours of scheduled appointments**. In the event that your appointment is not canceled, a no-show fee will be added to your account. All no-show appointments will be rescheduled to prevent lapses in patient care. When a patient fails to cancel an office visit in a timely manner, our office staff resources, staff time, and equipment are wasted and other patients are limited access to our services

- **$50 NO SHOW fees apply to established patient appointments, Ultrasounds, Treadmill Stress Test, Sleep Study, ABI & Heart Monitors ***Requires 24 HR notice*****
- **$200 NO SHOW fees apply to Nuclear Stress Test ***Requires 24 HR notice*****
- **$200 NO SHOW fees apply to Vein Ablations***Requires 48 HR notice*****
- **$250 NO SHOW fees apply to Heart Catherization ***Requires 48 HR notice*****

- ***Late cancellations: Late cancellations will be considered as a "no-show" or missed appointment.***
- **Please be advised that no-show charges are patient responsibility and will not be billed to your insurance.**
- **After (3) "NO SHOWS" in a (12) twelve month period the patient may be dismissed from the practice.**
- **A copy of this agreement shall be as valid as the original.**

_____ _____

Patient/Guardian Signature **Date**

PHYSICIAN OWNERSHIP DISCLOSURE FORM

Sleep Tight Center is a physician owned facility and your physician may have financial interest in the center. You have the right to choose where you receive medical care services. Therefore, you have the option to use a healthcare facility other than Sleep Tight Diagnostic Center. You will not be treated differently by your physician if you choose to obtain healthcare services at a facility other than Sleep Tight Diagnostic Center. If you have any questions concerning this notice, please feel free to ask your physician or any representative at Sleep Tight. We welcome you as a patient and value our relationship with you.

By signing below, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Sleep Tight Diagnostic Center.

_____ _____

Patient/Guardian Signature **Date**

CONSENT FOR TREATMENT

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

_____ _____ _____

Printed Name **Signature** **Date**

ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND FINANCIAL AGREEMENT

I authorize payment to my physician of any health insurance benefits that are payable to me, including Medicare and/or Medicaid payments, secondary insurance payments, and/or payments under any Employer Self-Funded Medical Expense Reimbursement Plan as governed by the Employee Retirement Income Security Act (ERISA), and/or payments from private insurance companies. I certify that the information that I gave to my physician's office to bill for payment is correct. I assign and transfer to Woodlands Heart and Vascular and Dr. Laura Fernandes or their agents the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due to my physician and I understand that I have to pay my physician for all charges not paid by my health insurance. This payment authorization, assignment of benefits, and agreement for financial responsibility is also binding on my administrators, executors, heirs, and successors. My signature confirms that I have read this assignment of benefits and that I understand this assignment of benefits, and that all of my questions have been answered.

_____ _____

Signature **Date**

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Woodlands Heart and Vascular Institute Policies and Procedures and HIPAA patient forms.

_____ _____

Signature **Date**

HIPAA RECEIPT ACKNOWLEDGEMENT

I understand and have been provided with a ***Notice of Information Practice*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to use of my health information. 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 Practice 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 Practice has already taken action in reliance thereon.

_____ _____

Signature **Date**

WOODLANDS HEART & VASCULAR INSTITUTE

CONTACT CONSENT FORM

Patient Name: _____DOB: _____

HIPAA IS AN ACRONYM FOR THE Health Insurance Portability & Accountability Act

Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique identifiers for health plan, providers, individuals, and employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our office policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, and/or cell phone with the exception of appointment reminders that reveal the doctor's name, date, and time only. In the instance when we are returning a phone call and have to leave a message with an unauthorized person no information will be left.

If you wish to authorize us to leave a message and/or release information to someone other than yourself please complete the following information:

Name:_____**Relation**:_____**Phone**:_____

Name:_____**Relation**:_____**Phone**:_____

Name:_____**Relation**:_____**Phone**:_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare

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

- A basis for planning my care and treatment
- A means of communications among the healthcare professionals involved in my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided

Special Situations: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work related injuries or illness. We may disclose medical information about you for public health activities such as to prevent or control disease, injury, disability, and driving, etc.

_____ _____

Signature **Date**

WOODLANDS HEART & VASCULAR INSTITUTE

CONTACT CONSENT FORM

Patient Name: _____DOB: _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. *If you wish to have your medical or billing information released to family members you must sign this form.* Signing this form will only give information to family members indicated below.

I authorize Woodlands Heart and Vascular Institute to release information to the persons listed below:

1. **Name**:_____**Relation**:_____
2. **Name**:_____**Relation**:_____
3. **Name**:_____**Relation**:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

_____ _____

Signature **Date**

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Office: (832)562-3974 Fax: (832) 663-9378 or (281) 771-3542

Authorization for Release of Medical Records

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

I hereby authorize **Woodlands Heart & Vascular Institute** to ( ) release **TO** ( ) receive **FROM**

_____ _____
Person or Organization Address

_____ _____ _____
Phone Fax City, State, Zip code

INFORMATION TO BE RELEASED

- ☐ **Complete medical records**
- ☐ Billing Information **Date range: _____ to _____**
- ☐ EKG/Echo Cardiology Report **MOST RECENT**
- ☐ CT Report **Date range: _____ to _____**
- ☐ Labs **MOST RECENT or Date range: _____ to _____**
- ☐ Progress notes **Date range: _____ to _____**
- ☐ Stress Test **MOST RECENT or Date range: _____ to _____**
- ☐ **Other: _____**

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (365 days) from the date of my signature, **unless** specified in writing here: _____. I understand that it may take up to 15 business days for the revocation to take effect. I understand that if the recipient authorized to receive the information is not covered entity, e.g. insurance company of non-health care provider; the released information my no longer be protected by the federal and state privacy regulations.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stating in this consent. Any other use of this information without the expressed written consent of the patient is prohibited. These records may be protected by Federal Regulation (42) CFR, part 2.

Fees: No applicable fee for provider to provider. Patient printed copies $0.25 per page, not to exceed $35.

_____ _____
Signature of Patient or Legally Authorized Representive **Date**

_____ _____
Printed of Patient or Legally Authorized Representive **Date**

_____ _____
Witness- Printed Name and Signature **Date**

WOODLANDS HEART & VASCULAR INSTITUTE

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

NOTICE OF INFORMATION PRACTICES

(For your records only)

Woodlands Heart and Vascular Institute may use and disclose protected health information for treatment, payment, and healthcare operations, health related benefits and services, release of information to designated individual entities, and other disclosures as required by law. Examples of this include, but are not limited to, requested life insurance, referral to nursing homes, home health agencies, and/or referral to other providers for treatment, or collection agencies. Healthcare operations include, but are not limited to, internal quality control, quality assurance, and auditing of records.

Woodlands Heart and Vascular Institute is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. These circumstances include, but are not limited to, cases of public health requirements or court orders.

Woodlands Heart and Vascular Institute will not make any other use or disclosure of patient's protected health information without the individual's written authorization. The individual may revoke such authorization at any time. Any revocation of authorization must be submitted in writing.

Woodlands Heart and Vascular Institute may contact the patient to provide appointment reminders, information regarding treatment recommendations, or other health-related issues that may be of interest to the patient or the concern of the Physician.

Woodlands Heart and Vascular Institute will abide by the terms of this notice, or the notice currently in effect at the time of disclosure. PULSE- Heart, Valve, and Vascular Institute reserves the right to change the terms of this notice and make new notice provisions effective for all protected health information it maintains.

Woodlands Heart and Vascular Institute will provide each patient with a copy of any revisions to the Notice of Information Practices at the time of their next visit, if requested, or at their last known address, if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the Practice please contact the Privacy Officer and/or the HIPAA Compliance Officer at the address and phone number listed below. All complaints will be addressed and the results reported to the Physician.

Woodlands Heart & Vascular Institute, P.A.
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