

NORTH TEXAS ARRHYTHMIA ASSOCIATES, PA

R. HARIS NASEEM, MD | ANDREW OWENS, MD

Demographic Information

Name		Date of Birth		Sex Male / Female	
Social Security Number		Email		Marital Status Single / Married / Widowed / Divorced / Other	
Mailing Address			City/State		Zip Code
Primary Phone		Secondary Phone		Work Phone	
I authorize detailed messages containing pertinent medical information to be left in a voicemail at the following numbers: <input type="checkbox"/> Primary Phone <input type="checkbox"/> Secondary Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Emergency Primary <input type="checkbox"/> Emergency Secondary					
Employer			Spouse/Parent's Name		
Emergency Contact's Name			Relationship to Patient		
Emergency's Primary Phone			Emergency's Secondary Phone		
Primary Care Physician		Cardiologist		Referring Physician	
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			Language <input type="checkbox"/> English <input type="checkbox"/> Other _____		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander			Appointment Confirmation Preference <input type="checkbox"/> Email <input type="checkbox"/> Primary Phone <input type="checkbox"/> None <input type="checkbox"/> Other Contact _____		

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		<input type="checkbox"/> All <input type="checkbox"/> Scheduling <input type="checkbox"/> Medical <input type="checkbox"/> Billing
2.		<input type="checkbox"/> All <input type="checkbox"/> Scheduling <input type="checkbox"/> Medical <input type="checkbox"/> Billing
3.		<input type="checkbox"/> All <input type="checkbox"/> Scheduling <input type="checkbox"/> Medical <input type="checkbox"/> Billing
4.		<input type="checkbox"/> All <input type="checkbox"/> Scheduling <input type="checkbox"/> Medical <input type="checkbox"/> Billing

I have reviewed the above information and authorize my protected health information to be released to the individuals listed, as specified. I understand that this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization, in writing, at any time.

Signature of Patient/Legal Representative

Date

Insurance Information

Primary	Secondary	Tertiary
Name of Insured	Name of Insured	Name of Insured
Insured Date of Birth	Insured Date of Birth	Insured Date of Birth
Relationship to Patient	Relationship to Patient	Relationship to Patient
Member ID/ Policy #	Member ID/ Policy #	Member ID/ Policy #
Group #	Group #	Group #

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Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our Patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, Visa or Mastercard.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This offices' policy is to collect this co-payment when you arrive for your appointment.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the Patients' share of the medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the Patients' responsibility is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office or from your insurance.

Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

I have read and understand the financial policy of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of Patient

Date of Birth

Signature of Patient/Legal Representative

Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed, or have been given the opportunity to review this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

** If you would like to receive a copy of our Notice of Privacy Practice, please ask an associate.*

Printed Name of Patient

Date of Birth

Signature of Patient/Legal Representative

Date

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Main Office Location

2609 Scripture Street

Denton, TX 76201

Phone: 940.565.0800 Fax: 940.565.0884

Authorization to Release Healthcare Information

This is a release form for authorization of your medical information to be transferred between **health care providers, health insurance companies and any other party involved in your medical care.**

I, _____, hereby authorize the following facilities/hospitals and doctor(s) to release all medical information to North Texas Arrhythmia Associates, PA to better manage my health.

This request includes: hospital summaries, echocardiogram reports, cardiac catheterization reports, laboratory reports, electrocardiograms, physician progress notes, and any other healthcare information relating to my condition.

**List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:*

1 _____

2 _____

3 _____

4 _____

5 _____

Printed Name of Patient

Date of Birth

Signature of Patient/Legal Representative

Date

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Health History Questionnaire

Name		Date of Birth	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other			
Occupation <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part time <input type="checkbox"/> Student			
Cardiac Device: <input type="checkbox"/> N/A <input type="checkbox"/> Medtronic <input type="checkbox"/> St. Jude Boston <input type="checkbox"/> Scientific <input type="checkbox"/> Biotronik <input type="checkbox"/> Other			Advanced Directive <input type="checkbox"/> Yes <input type="checkbox"/> No
List any Medical problems that you have been previously diagnosed with			
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease	Other
<input type="checkbox"/> Atrial Flutter	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Lung Disease	Other
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer	Other
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Pacemaker or Defibrillator	Other
List any past surgeries			
Year	Surgery	Hospital	
List any hospitalizations from the past 24 months			
Date	Reason	Hospital	
Medication List			
Medication	Dosage	Medication	Dosage
Please List Any Allergies:			
Social History			
Tobacco Usage	<input type="checkbox"/> Never <input type="checkbox"/> Used for _____ years <input type="checkbox"/> Quit years/months _____ ago		
	_____ Cigarettes per day/week	_____ Chew per day/week	_____ Pipes per day/week _____ Cigars per day/week
Exercise	<input type="checkbox"/> Rarely or Never Exercise <input type="checkbox"/> Frequently Exercise <input type="checkbox"/> Occasionally Exercise <input type="checkbox"/> Exercise Daily		
Caffeine	<input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola <input type="checkbox"/> Energy Drink <input type="checkbox"/> None	Cups per Day:	
Alcohol	<input type="checkbox"/> Never <input type="checkbox"/> _____ Drinks Per Day <input type="checkbox"/> _____ Drinks Per Week <input type="checkbox"/> _____ Drinks Per Month		
Recreational Drugs	<input type="checkbox"/> Never <input type="checkbox"/> Previously <input type="checkbox"/> Currently		
List any Significant family medical history such as heart disease, diabetes, hypertension, stroke, heart rhythm problems			
Mother		Father	
Grandmother		Grandfather	

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Siblings	Other
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