NORTH TEXAS ARRHYTHMIA ASSOCIATES, PA

R. HARIS NASEEM, MD | ANDREW OWENS, MD

Demographic Information

Name	**Date of Birth**	**Sex** Male / Female
Social Security Number	**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:

☐Primary Phone ☐ Secondary Phone ☐ Work Phone ☐ Emergency Primary ☐ Emergency Secondary

Email	**Do you want to receive email appointment reminders?** ☐ Yes ☐ No
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 ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	**Language** ☐ English ☐Other_____
Race ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐Other ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander	**Appointment Confirmation Preference** ☐Email ☐Primary Phone ☐None ☐Other Contact_____

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		☐All ☐Scheduling ☐Medical ☐Billing
2.		☐All ☐Scheduling ☐Medical ☐Billing
3.		☐All ☐Scheduling ☐Medical ☐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**

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 ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Occupation ☐ Retired ☐ Unemployed ☐ Employed Full Time ☐ Employed Part time ☐ Student

Cardiac Device:	**Advanced Directive**
☐ **N/A** ☐**Medtronic** ☐ **St. Jude** ☐ **Boston Scientific** ☐ **Biotronik** ☐ **Other**	☐**Yes** ☐**no**

List any Medical problems that you have been previously diagnosed with

☐ Atrial fibrillation	☐ Heart Attack	☐ Kidney Disease	Other
☐ Atrial Flutter	☐ Congestive Heart Failure	☐ Lung Disease	Other
☐ Diabetes	☐ Stroke	☐ Cancer	Other
☐ Hypertension	☐ Coronary Artery Disease	☐ 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: ☐ **NONE**

Social History

Tobacco Usage	☐ Never	☐ Used for_____ years	☐ Quit years/months _____ ago	
	____Cigarettes per day/week	____Chew per day/week	____Pipes per day/week	____Cigars per day/week

Exercise ☐ Rarely or Never Exercise ☐ Frequently Exercise ☐ Occasionally Exercise ☐ Exercise Daily

Caffeine ☐ Coffee ☐ Tea ☐ Cola ☐ Energy Drink ☐ None **Cups per Day:**

Alcohol ☐ Never ☐ _____ Drinks **Per Day** ☐ _____ Drinks **Per Week** ☐ _____ Drinks **Per Month**

Recreational Drugs ☐ Never ☐ Previously ☐ Currently

List any Significant family medical history such as heart disease, diabetes, hypertension, stroke, heart rhythm problems

Mother	**Father**
Grandmother	**Grandfather**
Siblings	**Other**