Patient Demographics

Please indicate below the preferred # to contact you (i.e. Hm, Wk, Cell or other)

Name _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Ph#1_____Ph#2 _____ Email_____

Marital Status: Single _____ Married _____ Widowed _____ Separated _____Divorced _____ Sex: Female _____ Male ____

Preferred Language: _____ Ethnicity: Hispanic or Latino - Other

Race (Circle One) Asian, Black/African American, White, Native Hawaiian or Other Pacific Islander, Other, Decline to Report

Employer _____Occupation _____

Referring Physician_____ Primary Care Physician_____

Emergency Contact _____ Phone # _____ Relationship_____

Pharmacy (Name and Location) _____

Spousal Information

Name _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Ph#1_____Ph#2 _____Ph#3_____

Primary Insurance Information

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Insured Party_____ DOB _____ SSN _____

Relationship to Patient _____ Phone # _____

Employer _____ Occupation _____

Secondary Insurance Information

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Insured Party_____ DOB _____ SSN _____

Relationship to Patient _____ Phone # _____

Employer _____ Occupation _____

Assignment of Benefits and Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to **Heart Institute of Brownsville** and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ Signature _____

Patient Online Access

We have introduced a new patient portal on our Website (www.urgentcareathib.com). Our webpage is a personal health record and patient portal all in one that lets you take a more active role in managing your care. Our new solution provides the following features:

- Online Notification of Results
- Prescription Renewal Requests (2-business day response time)
- Electronic Messaging to Providers and Staff (5-business day response time)
- Online Update of Demographic and Insurance Information

To create your web portal account, please provide your e-mail address and signature below. An invitation e-mail* will be sent to the provided address with instructions on completing the POA sign-up process.

***Be on the lookout for an email message from do-not-reply@waitingroomsolutions.com**

Please check one of the following:

☐ I agree that by providing my e-mail address below I am requesting a Patient Online Access Account and agree to have my test results and preventative health reminders provided to me through the Patient Online Access Portal.

EMAIL ADDRESS: _____

☐ I do not wish to have a Patient Online Access Account.

NAME (PRINT): _____ DATE OF BIRTH: _____

SIGNATURE: _____ TODAY'S DATE: _____

Patient Health Information Disclosure

I understand that as part of my healthcare, the physicians of Heart Institute of Brownsville, LLP (HIB) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

HIB's *Notice of Privacy Practices* provides specific information and complete description of how my private health information (PHI) may be used and disclosed. I have been provided a copy of our access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that HIB reserves the right to change the *Notice of Privacy Practices.* I understand that I have the right to restrict the use and/or disclosure of my PHI for treatment, payment or healthcare operations and that HIB is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that HIB has already taken action in reliance of my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies applied to all the PHI we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically).

NOTE: HIB must obtain your written authorization to use your PHI for any purpose other than treatment or billing. If you want HIB to have access to disclose your PHI to your spouse of any other person during your treatment, please list and sign below.

I agree to allow HIB to disclose my PHI (including date/time of appointments) to:
___ My Spouse_____ (printed name and phone number)
___ Other Member(s) of my Family_____
___ Other_____ (printed name and phone number)
___ Myself only, no other family member (does not apply to minors)
This does not serve as an Authorization to Release Medical Record

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed HIB's *Notice of Privacy Practices.*

_____ _____
Signature of Patient or Legal Representative Date

_____
Print Name of Patient or Legal Representative

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (Please Specify) _____

Witness: _____ **Date:** _____

Phone: (956) 504-3278 Fax: (956) 504-3287
www.HeartInstituteOfBrownsville.com

We want to take this opportunity to welcome you to the Heart Institute of Brownsville. Thank you for choosing and entrusting us as your health provider.

FINANCIAL POLICY

Payment is due at the time services are rendered. This includes self-pay, insurance co-pays, co-insurance, and/or deductibles according to your health insurance. It is your responsibility to inform us of any changes in your insurance or personal information, such as address and/or phone changes. If we are unable to verify your insurance benefits and your claim is denied, charges will become patient responsibility.

Personal Health Insurance

It is the patients responsibility to be aware of their own benefits and to provide accurate insurance information to file all medical claims. Patients will be responsible for providing most current insurance card and authorization and/or referral required by your insurance for every visit. We will file your claim and we can only estimate what your insurance will cover, this is NOT a guarantee of payment. If your claim is denied, you will be financially responsible for services rendered. For an explanation of your individual health insurance benefits and/or coverage, please contact your insurance coverage.

Self-Pay

Self-pay office visits rates are offered to self-pay patients which are due at the time of service. If special procedures are needed, additional charges and discounts will apply when services are rendered.

Pre-Collect Policy

If you have not met your deductible or have co-insurance, please expect a call from our finance department.
If you are having an Exam, Injection, X-Ray, or any other type of procedure, please be advised that prepayment will be due at time of service.

"I have read and agree to the provisions of this Financial Policy."

Signature:_____ Date: _____

Print Patient Name:_____ DOB: _____

www.heartinstituteofbrownsville.com
(956)504-3278 Main
(956)504-3287 Fax

213 Heart Drive
Brownsville, TX 78520

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court of administrative order.
3. If required to do so by the law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by the law.
7. To correctional institutions or law enforcement officials, if you are an inmate, or under the custody of a law enforcement official.
8. For Worker's Compensation or similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request restrictions in our use or disclosures of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by the law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request to: Heart Institute of Brownsville 213 Heart Drive, Brownsville, TX 78520.

www.heartinstituteofbrownsville.com
(956)504-3278 Main
(956)504-3287 Fax

213 Heart Drive
Brownsville, TX 78520

4. You may ask to amend your health information if you believe It is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing to: Heart Institute of Brownsville 213 Heart Drive, Brownsville, TX 78520. You must provide us with a reason that supports your request for an amendment.
5. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and human Services. To file a complaint with our practice, write to: Heart Institute of Brownsville 213 Heart Drive, Brownsville, TX 78520 (956) 504-3278. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide and authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please call or come by Heart Institute of Brownsville 213 Heart Drive, Brownsville, TX 78520. (956) 504-3278.

I hereby acknowledge that I have been presented with a copy of the Heart Institute of Brownsville's Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____

Patients Printed Name