A-FormLett

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: ______________________
Date of Birth:
Social Security No.:
Phone: ( ) ______ - __________

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) ______ - __________

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Mail

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

I authorize Southeast Texas Cardiology Associates, II, LLP to obtain/have access to my medication history.

Signed ____________________________________ Date: ______________

RISKS FOR HEART ATTACK, HEART DISEASE, OR STROKE

PLEASE CHECK ALL THAT APPLY

Recent research shows that sleep apnea is associated with many serious conditions. Left untreated it is a contributing risk factor in high blood pressure, diabetes, depression, impotence, heart disease, stroke and death.

[ ] I have been told I snore.

[ ] I have been told I stop breathing when I sleep.

[ ] I am always sleepy during the day even though I sleep throughout the night.

[ ] I have high blood pressure.

[ ] I have been told I am a restless sleeper. I toss and turn while sleeping.

[ ] I tend to sweat excessively while I sleep.

[ ] I frequently wake up with headaches.

[ ] I tend to fall asleep in inappropriate situations.

[ ] Others and/or I have noticed a recent change in my personality.

[ ] I am overweight.

Using the scale of: 0 – would never doze or sleep, 1 – slight chance of dozing or sleeping, 2 – moderate chance of sleeping or dozing, 3 – high chance of sleeping or dozing

Sitting and reading. ________

Watching TV. ________

Sitting inactive in a public place. ________

Being a passenger in a car for an hour without a break. ________

Lying down to rest in the afternoon. ________

Sitting and talking to someone. ________

Sitting quietly after lunch (w/o alcohol). ________

Sitting for a few minutes in traffic while driving. ________

Peripheral arterial disease (PAD) – is a serious circulatory condition in which the blood vessels that carry blood to your arms, legs, brain or kidneys become narrowed or clogged. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficulty controlling blood pressure, or symptoms of stroke. People with PAD are at a significantly higher risk for stroke and heart attack.

[ ] I have foot, calf, buttock, hip, or thigh discomfort (aching, fatigue, tingling, cramping or pain) when I walk, which is relieved by rest.

[ ] I experience pain in lower leg(s) or feet at rest.

[ ] I have pale, discolored or bluish toes.

[ ] I have skin wounds or ulcers on feet or toes that are slow to heal (8-12 wks.).

[ ] A doctor has told me I have diminished or absent pedal (foot) pulses.

[ ] I have suffered a severe injury to my leg(s) or feet.

[ ] I have an infection of the leg(s) or feet that may be gangrenous (black skin tissue).

Chronic venous insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. Symptoms include: varicose veins, skin problems, leg and ankle swelling, tight calves and legs that feel heavy, tired, restless or achy. Pregnancy, obesity, smoking, standing or sitting for long periods of time, and lack of exercise can increase the risk of CVI.

[ ] My legs are swollen, painful, red or warm to the touch.

[ ] I have had a blood clot in a vein that caused inflammation, pain or irritation.

[ ] I have varicose veins (enlarged, swollen, and/or raised above the surface of the skin) in my legs.

[ ] I have had a Deep Vein Thrombosis (DVT) in the past and I am experiencing pain, swelling, changes in skin color, cellulites, or non-healing ulcers.

[ ] My legs feel heavy, tired, restless or achy.

[ ] If I push on my swollen foot, ankle or leg for 10 seconds and release, my fingertip leaves a dimple.

[ ] If my feet, legs or ankles are swollen, the skin looks stretched and/or shiny.

[ ] I have an ulcer on the inside of my ankle.

SOUTHEAST TEXAS CARDIOLOGY ASSOCIATES II, L.L.P.
SUMMARY OF NOTICE OF PRIVACY PRACTICES

- **Uses and Disclosures of Health Information**

We will use and disclose of your health information in order to treat you or assist other healthcare providers treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

- **Uses and Disclosures Based on Your Authorization**

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

- **Uses and Disclosures Not Requiring Your Authorization**

For certain limited research purposes, unless you object
For purposes of public health and safety
To Government agencies for purposes of their audits, investigations and other oversite activities
To Government authorities to prevent child abuse or domestic violence
To the FDA to report product defects or incidents
To law inforcement authorities to protect public safety or to assist in apprehending criminal offenders
When required by court orders, subpoenas and as otherwise required by law

- **As our patient, you have the following rights**

To have access to and/or copy of your health information
To receive and accounting for certain disclosures we have made of your health information
To request restrictions as to how your health information is used or disclosed
To request that we communicate with you in confidence
To request we amend your health information
To receive notice of our privacy practices

If you have a question, concern, or complaint regarding our privacy practices, please refer to the attach Notice of Privacy Practices for the person or persons whom you may contact. For a detailed description of how our office will protect your health information, your right as a patient and our common practices in dealing with health information, please Email or call our office.

Acknowledgement of Review of Privacy Practices

I have reviewed this office's 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 this document.

____
Signature of Patient / Legal Guardian

____
Print Name of Signature

SOUTHEAST TEXAS CARDIOLOGY ASSOCIATES II, L.L.P.
CONSENT TO MEDICAL TREATMENT

PLEASE READ CAREFULLY BEFORE SIGNING

PATIENT NAME:____________________DATE OF BIRTH: ___________

CONSENT TO MEDICAL TREATMENT/AUTHORIZATION TO RELEASE INFORMATION
I (for) undersigned patient to hereby voluntarily consent to such medical care involving routine diagnostic procedures and medical treatment by my attending physician, his assistants or his designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this hospitalization/medical treatment. I further authorize the provider/physician to release to the insurers herein, specified, or to any agency concerned with the payment of my charges, any and all information (including copies of records) relating to this medical treatment.

RELEASE OF MEDICAL RECORDS TO TRANSFERRING FACILITY
I authorize the release of my medical records to the health care physician in order to provide continuity of medical treatment.

MEDICARE – PATIENT'S CERTIFICATION
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim, I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF INSURANCE BENEFITS/DISTRIBUTION OF OVERPAYMENT/OBLIGATION OF GUARANTOR
Each of the undersigned hereby authorize all of (his) insurers, whether or not specified, to make payments of medical insurance benefits directly to the provider/physician rather than to said undersigned, but such payments shall not exceed the provider regular charges not paid or covered by said insurers. Each of the undersigned insured also hereby authorize any overpayment to the provider/physician regarding this hospitalization which would otherwise be payable to said undersigned to be applied and credited against my previous balance due to the medical treatment for which said undersigned is the responsible party.
I also irrevocably assign to the provider/physician all rights, title and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover.
I the undersigned guarantor, hereby guarantee full and prompt payment to the provider/physician of all charges made as a result of services rendered the above-named patient during this medical treatment. I agree to pay the provider/physician for said charges upon the failure of said patient, any responsible insurer or any other person or firm to pay same when due. The patient is responsible for any legal or court costs required in the collection of any unpaid accounts.

PHYSICIAN SERVICES/AUTHORIZATION TO RELSEASE INFORMATION/ASSIGNED OF INSURANCE BENEFITS
I hereby authorize the release of any medical information necessary to process this claim. I hereby authorize payment directly to

R.P. Sotolongo, M.D. Paris Bransford, M.D. Christy Lowrance, P.A.-C

Of the physicians service benefits, if any otherwise payable to me for their services described. I understand that I am financially responsible for the charges not covered by this authorization.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENT.

______________________________ ______________________________
Patient Insured Witness

____
Guarantor Insured

MEDICAL RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protective health information, to the person(s) or entity listed below.

____

HIV/AIDS: I consent to the release of any positive or negative tests results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initials: ____________

Date: ____________

PRINT PATIENT NAME: ______________________________

PATIENT DOB: ______________________________

PATIENT SOCIAL SECURITY NUMBER: ______________________

Limitations on the following information you may release subject to this Release Form are as follows:

____

____

Release my protected health information to the following person(s) entity:

Name: SOUTHEAST TEXAS CARDIOLOGY ASSOCIATES II, L.L.P.

Address: 2693 NORTH ST.

City: BEAUMONT State: TX ZIP: 77702

The reasons or purposes for this release of information are as follows:

____

____

Patient Signature (or guardian/legal representative) Date:

____

I understand that you will provide this information within 15 days from the receipt of this request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the TEXAS STATE BOARD of Medical Examiners.

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Print Patient Name: ______________________________________

You may release my health information

______Test Results ______ Office Visits ______ Lab Work

______ Appointment Time ______All Records

Other

I wish to be contacted in the following manner:

Home Phone # ____

Work Phone # ____

______ OK to leave message with detailed information
______ Leave message with call back number only

Written Communication

______ OK to mail to my home address ______ OK to mail to home/work
______ OK to fax to this number

You may release the above information to the following.
(check and print name)

______ Self Only ______ Spouse

______ Daughter:

______ Son:

______ Grandchild:

Other than above:______________________________________

____
Signature of Parent/Legal Guardian **Date**

setxcardiology.com

PROVIDE SETCA WITH YOUR E-MAIL ADDRESS & RECEIVE E-MAIL INVITATION

HOME PAGE:

✓ **Patient Portal**:
Sign in with email address and password

✓ **Home**: Health history
Patients can send messages to providers

✓ **Appointments**: Upcoming, Recommended, Past, medical forms
View upcoming appointments
Check messages to review appointment requests
Request appointments

✓ **Messages**: Inbox, Compose message, Sent messages, Archived (saved) messages
Compose (create) and send message
Edit contact preferences (phone call, text, email, mail)

✓ **Billing**: Recent charges, Payment history, Payment methods, statements, closed charges
Send message to billing department

✓ **My health**: Test results, Medications, Care summaries, Vitals, Medical History
Send messages to providers and office staff

✓ **Tasks and Tools**: Download Health Data, Transmit Health Data, Referrals, Learning Materials, Portal Activity

✓ **My Profile**: Contact Information, Security Settings, My Notifications, Insurance, Family Access, Test Results Pin

Health and wellness *Search*: Enter health topic or symptoms