Cardiac Electrophysiology Consultants of South Texas, P.A.

Registration

Thoughts about privacy: please do not put down information that you would prefer to keep private. We make every effort to protect your data, but current and/or future regulations and laws may make this difficult. If you will be paying for services without involving a third-party payor, all we need below is some way to communicate with you.

Name:	**Today's date:**
Date of Birth:	**Marital Status:**(please circle) *Single Married Other*
Street Address:	
City, State, Zip:	
Phone (home):	**Phone (work):**
Phone (cell):	**Email:**
Guardian (if any):	
Emergency contact: (name, phone, address)	
Referred by:	

Insurance and Billing Information

Billing Name (if other than patient) **and Relationship:**
Billing Street Address:
Billing City, State, Zip:
Billing Telephone/Email:

Payment is required at the time of service unless prior arrangements have been made. Thank you.

Insurance Company #1: **Address:**
Name of Insured: **Relationship:**
Insured ID and Group numbers:
Company telephone number:

Insurance Company #2: **Address:**
Name of Insured: **Relationship:**
Insured ID and Group numbers:
Company telephone number:

Assignment of Benefits

Assignment of Insurance Benefits

I hereby authorize direct payment of all insurance benefits, including Medicare, Medicaid, and the above-named Medigap (if any), to Cardiac Electrophysiology Consultants of South Texas, P.A., for services rendered by Dr. Lawrence E. Widman in person or under his supervision. I authorize any holder of medical information about me to release to all insurance payors any information needed to determine correct payment. A photocopy or fax of these assignments shall be as valid as the original. I understand that I am financially responsible for any balance not covered by my insurance(s).

Certification of Provided Information

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request consistent with government (HIPAA) regulations and the HIPAA policy of Cardiac Electrophysiology Consultants of South Texas, P.A. I request that payment of authorized benefits be made on my behalf.

Patient Name (please print) Date
Parent/Guardian (please print) Signature

 February 26, 2003

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Cardiac Electrophysiology Consultants of South Texas, P.A.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Cardiac Electrophysiology Consultants of South Texas, P.A.**. I understand that diagnosis or treatment of me by **Dr. Lawrence Widman** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Cardiac Electrophysiology Consultants of South Texas, P.A.** is not required to agree to the restrictions that I may request. However, if **Cardiac Electrophysiology Consultants of South Texas, P.A.** agrees to a restriction that I request, the restriction is binding on **Cardiac Electrophysiology Consultants of South Texas, P.A.** and on **Dr. Lawrence Widman**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Lawrence Widman** or **Cardiac Electrophysiology Consultants of South Texas, P.A.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Cardiac Electrophysiology Consultants of South Texas, P.A.**'s Notice of Privacy Practices prior to signing this document. The **Cardiac Electrophysiology Consultants of South Texas, P.A.**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Cardiac Electrophysiology Consultants of South Texas, P.A.**. The Notice of Privacy Practices for **Cardiac Electrophysiology Consultants of South Texas, P.A.** is also provided **in the patient Waiting Room** and on the **Cardiac Electrophysiology Consultants of South Texas, P.A.**'s website at **www.cecst.com**. This Notice of Privacy Practices also describes my rights and the **Cardiac Electrophysiology Consultants of South Texas, P.A.**'s duties with respect to my protected health information.

Cardiac Electrophysiology Consultants of South Texas, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Cardiac Electrophysiology Consultants of South Texas, P.A.**'s website (**www.cecst.com**) or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective January 1, 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year_____

ADDRESS _____

_____

CITY _____ **STATE**_____ **ZIP**_____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to other covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.506(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective January 1, 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests.

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization.

Authorizations for Marketing Purposes - If this authorization is being provided or obtained for marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must also clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code § 181.152; 45 C.F.R § 164.508(a)(3)).

Limitations of this form - This authorization form should not be used for: (1) the disclosure of any health information as it relates to health benefits plan enrollment and/or related enrollment determinations (45 CFR §§164.508(b)(4)(ii), .508(c)(2)(ii)); or (2) the use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(3)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Cardiac Electrophysiology Consultants of South Texas, P.A.

Patient Name:_____Date:_____ DOB:_____
Referring Physician:_____

Health History Form

Age_____How would you rate your general health ? ___ Excellent ___ Good ___ Fair ___ Poor
Main reason for todays visit:_____
Other Concerns:_____
Allergies:_____

Review of Symptoms: Please check and circle any current symptoms you have.

Constitutional
___ Fever/ sweats
___ Unexplained weight loss/gain
___ Unexplained fatigue/ weakness

Eyes
___ Change in Vision

Ears/ Nose/ Throat/ Mouth
___ Difficulty hearing/ ringing in ears
___ Hay fever / allergies/ congestion
___ Trouble swallowing

Cardiovascular
___ Chest pain/Discomfort
___ Palpitations
___ Shortness of Breath with or without exertion
___ Syncope/ Presyncope

Breast
___ Breast Lump
___ Nipple Discharge
___ Pain

Respiratory
___ Coughing/ wheezing
___ Coughing up blood

Gastrointestinal
___ Heartburn/ Reflux
___ Blood or change in bowel movement
___ Nausea/vomiting/ diarrhea
___ Pain in abdomen

Genitourinary
___ Painful/ bloody urination
___frequent urination
___ Nighttime urination
___ Discharge: penis or vagina
___ Unusual vaginal bleeding

Musculoskeltal
___ Muscle / joint pain
___ Recent back pain

Skin
___ Rash
___ New or change in mole

Neurological
___ Headaches
___ Memory loss

Psychiatric
___ Anxiety/ Stress
___ Insomnia

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/ bleeding

Endo
___ Cold/heat intolerance
___ Increased thirst/ appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ___ Yes ___ No

Patient Name:_____Date:_____ DOB:_____

Personal Medical History: Please indicate whether you have had any of the following medical problems (with dates).

___ Heart Disease:
specify_____
___ Asthma/ Lung Disease
___ High Blood Pressure
___ Diabetes
___ High Cholesterol
___ Thyroid
___ Kidney disease
___ Cancer:
Specify:_____

Other:_____

Surgical History: Please list all prior operations (with dates).

_____ _____ _____

_____ _____ _____

Social History

Do you drink caffeine? ___ No ___ Yes (coffee, tea, soda)____ Cups/ day

Do you smoke? ___No ___ Yes ___ Quit When_____
Current smoker: Packs/ day _____ # of years _____

Do you drink alcohol? ___ No ___ Yes # of drinks a week_____ Type of beverage _____

Do you use recreational drugs? ___ No ___ Yes Type _____

Socioeconomics:

Occupation:_____ Employer: _____

Years of education/ highest degree:_____ Marital Status: Single Married Divorced Widowed

Number of children:_____ How is their health: _____

Family History

Fathers Health History:_____

Mothers Health History:_____

Sib's Health History:_____

Familial Diseases: Please indicate and specify if there is a family history of the following diseases.

1. Sudden Cardiac Death _____
2. Coronary Artery Disease below the age of 55_____
3. Adult onset of Diabetes_____
4. Long Q-T Syndrome_____

Patient Name	DOB	Home Number	Pharmacy Number
Allergies:			

Medication	Dosage	How Often Taken/ What time of day morning, noon, or night	Who prescribed this medication

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For Office Use Only

Reviewed By	Date