REDDY CARDIAC WELLNESS

3519 Town Center Blvd S Ste. A• Sugar Land, TX 77479•PH (281) 491-0044• FAX (281) 491-1802

PATIENT INFORMATION

PLEASE PRINT LEGIBLY

PRIMARY DOCTOR: _____

TODAY'S DATE: _____

DOCTOR'S PHONE#:_____

LAST NAME: _____FIRST NAME: _____MI ____

ADDRESS: _____APT.No_____

CITY: _____STATE: _____ZIP CODE: _____-_____

HOME PHONE No. :(_____) _____CELL PHONE No. :(_____)_____

DATE OF BIRTH: _____ GENDER: *MALE / FEMALE*

SOCIAL SECURITY#:_____ DL#:_____

EMAIL ADDRESS: _____

MARITAL STATUS: *SINGLE / MARRIED / DIVORCED / WIDOWED*

WORK STATUS: *UNEMPLOYED / PART-TIME / FULL-TIME / RETIRED / SELF-EMPLOYED / STUDENT*

EMPLOYER NAME: _____WORK PHONE# :(_____) _____

How Did You Hear About Us? Physician / Friend / Patient / Internet / Newspaper / Magazine / DVD

Name of Referral Source: _____

Emergency Contact: _____ Phone No:_____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone No: (____) _____

ID No. _____ GROUP No. _____

Secondary Insurance Company: _____ Phone No. (_____)_____

ID No. _____ GROUP No. _____

POLICY HOLDER INFORMATION

Relationship to patient: Self / Parent / Spouse (If self, please disregard completing this section)

Last Name: _____ First Name: _____MI _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Date of Birth: _____

Social Security #:_____ Phone No._____

Employer Name: _____ Work Phone No.: (_____) _____

Is this person currently a patient at this office ☐ Yes ☐ No

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FINANCIAL AND OFFICE POLICIES

1. All copays, deductibles and co-insurances are due at the time of service. Co-payments are amounts that you have agreed to pay at each doctor's office visit with your insurance company. Many insurance plans also include an annual deductible amount that is your responsibility. **Please be prepared to pay both at the time of your visit.**

2. We accept cash, check, MasterCard, Visa, Discover and American Express.

3. Insurance benefits will be assigned to the physician. All insurances will be filed for the patient providing we are able to identify eligibility.

4. Statements will be mailed the first week of each month and payment is expected before the 30th of the same month for any remaining balance after your PPO or HMO plan pays its share.

5. Failure to respond to three statements requesting payment will cause us to begin collective action with either a collection agency or an attorney.

6. There will be $25.00 fee for all returned checks and must be resolved as soon as possible. Any unresolved payments will be forwarded to the Attorney's office for collection.

7. There will NOT be any interest charge on balances are being paid off in a timely manner.

8. If your insurance company decides to hold payment to us until they receive "additional information" from you, it is your responsibility to provide that information to you insurance company immediately. They are looking for ways to delay or deny payment for medical care.

9. Established patients will be required to fill out forms every year or as requested.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Name of Patient (print) Social Security Number

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COPAYS, DEDUCTIBLES AND CO-INSURANCE AGREEMENT.

PATIENT COPAYS AND DEDUCTIBLE MUST BE COLLECTED AT THE TIME OF SERVICE PER THE TEXAS INSURANCE CODE (ARTICLE 21.24-1). THE TEXAS OCCUPATIONS CODE (SECTION 101.203) AND THE HEALTH AND SAFETY CODE (SECTION 311.0025) STATE IT **IS FRAUDULENT FOR A PHYSICIAN TO SUBMIT AN INSURANCE CLAIM THAT DOES NOT DISCLOSE A PLAN TO WAIVE PATIENTS COPAYS, CO-INSURANCE OR DEDUCTIBLES AMOUNTS.** IF YOU ARE NOT AWARE OR DO NOT AGREE WITH THE AMOUNT(S), PLEASE CONTACT YOUR CARRIER. IF YOU ARE DISPUTING THE VERIFIED AMOUNTS, **WE WILL NOTIFY YOUR INSURANCE THAT YOU ARE IN VIOLATION WITH YOUR CONTRACTUAL AGREEMENT AND FURTHER ACTION WILL BE TAKEN IF NECESSARY.** YOUR INSURANCE MAY THEN CHOSE THAT YOU PAY YOUR DEDUCTIBLE AMOUNTS DIRECTLY TO THEM OR YOUR MEDICAL PLAN COVERAGE MAY BE TERMINATED FOR NON-COMPLIANCE.

I,_____, AM AWARE OF MY CO-PAY, CO-INSURANCE AND/OR DEDUCTIBLE AMOUNT(S). REDDY & REYNOLDS CARDIOLOGY ASSOCIATES AGREES TO ADJUST ALL CONTRACTED AMOUNTS AS PER THEIR MANAGED CARE CONTRACT WITH MY CARRIER. I WILL BE BILLED FOR ANY AMOUNTS MY INSURANCE STATES AS MY RESPONSIBILITY.

SIGNATURE: _____DATE: _____

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Insurance Assignment of Benefits

Date_____

Name of Patient:_____

Name of Policy Holder: _____

Employer of Policy Holder: _____

Policy ID Number: _____**Policy Group Number:** _____

I hereby instruct and direct _____Insurance Company to pay by check made out for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered

Mail to: Kota J. Reddy, MD, P.A.
3519 Town Center Blvd. S. Ste. A
Sugar Land, TX 77479

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional charges over and above this insurance payment.

I also understand that I am expected to know my benefits under this plan and do not expect Reddy Cardiac Wellness to guarantee insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, referring or treating physician that may be involved in my care.

I authorize the physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date at _____ this_____ day of _____, 20_____.

_____ _____

Signature of Policy Holder **Witness**

_____

Signature of Claimant, if other than Policy Holder

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AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to the physician of the medical benefits and/or surgical, if any otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services.

SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE _____ DATE _____

Acknowledgement of Review of Notice of Privacy Practices:
I have been given the opportunity to review 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, which is available to me upon request.

Signature of Patient or Personal Representative _____ DATE _____

Name of Patient or Personal Representative's _____ Description of Personal Representative's Authority _____

Reconocimiento de Repaso del Aviso de Prácticas de Privacidad:
Afirmo que he repasado el Aviso de Prácticas de Privacidad de esta clínica, el que explica en qué manera utilizarán y compartirán mis datos médicos. Entiendo que tengo derecho a solicitar y que se me sea entrega una copia del Aviso de Prácticas de Privacidad.

Firma del Paciente o su Representante _____ Fecha _____

Nombre del Paciente o su Representante _____ Descripción de la Autoridad del Represéntate _____

Authorization for Disclosure of Protected Health Information

I authorize Reddy Cardiac Wellness to disclose my protected health information (PHI) to my family member(s) and/or friend(s) for the purpose of information, treatment and health care.
I understand that this authorization is valid until the time if and when it is revoked in writing.
□ **Yes** □ **No**

Name of Person Authorized for disclosure of my Protected Health Information _____ Relationship to patient _____

Patient Signature _____ Date _____

Print Patient Name _____ Witness _____

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Personal Medication List

Patient Full Name: _____ Today's Date: _____

Drug Allergies: _____

Local Pharmacy: _____ Pharmacy Phone No:_____

Instructions:

1. Please fill out each row entirely for each medication you take.
2. Be sure to include special instructions such as "with food," etc.
3. Include non-prescription medicine such as vitamins, pain relievers, antacids, laxatives, etc.
4. Carry your list in a purse or wallet and place a copy with your medical records.
5. Add any new medications you start and cross out those your doctor has stopped.

Prescription medication	Dose	Time(s) of Day	Reason for Taking	Special Instructions

Non-Prescription Medication	Dose	Time(s) of Day	Reason for Taking	Special Instructions

By signing this consent you are agreeing that your provider at Reddy Cardiac Wellness. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ _____

PATIENT SIGNATURE **DATE**

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PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

☐ Home Telephone _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

☐ Work Telephone _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

☐ Written Communication

- ❑ O.K. to mail to my home address
- ❑ O.K. to mail to my work/office address

☐ Other _____

_____

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed, properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

Date	Disclose to Whom Address or Fax	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=treatment Records P=payment information O= healthcare operations
(3) Enter how disclosure was made F=fax P=phone E=Email M=mail O=other

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PERIPHERAL VASCULAR DISEASE (PVD) RISK ASSESSMENT QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

Are your legs often tired or do your calves feel tight or ache when you walk or exercise?	**Y**	**N**
If "yes," do your legs feel better when you stop the activity?	**Y**	**N**
Do you experience leg heaviness or leg aching on a regular basis?	**Y**	**N**
If you checked "yes" to any of the questions above, talk to your physician to see if you need further tests to see if you have vascular disease in your legs.		

Which of these apply to you?		
High blood pressure	**Y**	**N**
High cholesterol	**Y**	**N**
Diabetes	**Y**	**N**
Sedentary (inactive) lifestyle	**Y**	**N**
Current/Former smoker	**Y**	**N**
Age more than 50	**Y**	**N**
Coronary artery disease	**Y**	**N**
Family history of stroke or vascular disease	**Y**	**N**
Leg swelling/edema	**Y**	**N**
Spider/varicose veins	**Y**	**N**
Family history of varicose veins	**Y**	**N**
If you checked "yes" to two or more of the risk factors listed above, your doctor may want to do further testing to see if you have peripheral vascular disease (PVD).		

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SLEEP DISORDER QUESTIONNAIRE

If you have one or more of the following symptoms, you probably have a sleep disorder called sleep apnea and may need a sleep study.
Please check all that apply.

- ❑ Snoring
- ❑ Problem sleeping (insomnia) or restless sleep
- ❑ Gasping for breath or choking, after a pause in breathing
- ❑ Daytime sleepiness
- ❑ Morning headaches
- ❑ Fatigue, loss of energy
- ❑ Sexual dysfunction (i.e. Impotence, lack of desire)
- ❑ Forgetfulness or trouble concentrating
- ❑ Irritability or mood changes
- ❑ Anxiety or depression
- ❑ Overweight
- ❑ Large neck size
- ❑ High blood pressure
- ❑ Drowsy while driving
- ❑ Waking up with a dry mouth
- ❑ Frequent leg jerking/ movements or restless legs
- ❑ Heartburn
- ❑ Frequent trips to the bathroom at night
- ❑ Excessive night sweating

Patient Name:_____

Date of Birth:_____ **Date:** _____