COASTAL CARDIOLOGY, PLLC

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613 Elizabeth, Suite 102, 402, 402A, 411 • Corpus Christi, Texas 78404 • (361) 887-2900 • (361) 826-0187
13725 Northwest Blvd., Suite 180 • Corpus Christi, Texas 78410 • (361) 387-1179

PATIENT REGISTRATION

Registracion de Paciente

PLEASE PRINT
Por Favor Use Letra de Molde

PATIENT (Paciente) LAST NAME (Apellido) FIRST NAME (Primer Nombre) MIDDLE (Segundo Nombre)

ADDRESS - Physical (Dirección - Permanente) STREET Calle) APT. # (Apartamento #) CITY / STATE / ZIP (Ciudad/Estado/Zip) HOME PHONE (Telefono # Celular) CELL PHONE (Telefono # Celular)

MAILING ADDRESS (Dirección de envío) E-MAIL (Dirección de correo electrónico)

EMPLOYED BY (Empleado Por) EMPLOYER'S ADDRESS (Dirección de Patron) OCCUPATION (Ocupacion) BUS. PHONE (Telefpono # Empleo)

DATE OF BIRTH (Fecha de Nacimiento) SOCIAL SECURITY NUMBER (Seguro Social #) MARITAL STATUS (Estado Civil) REFERRED BY (Referido Por)

NEAREST FRIEND OR RELATIVE FOR EMERGENCIES RELATIONSHIP TO PATIENT (Relacion al Paciente) PHONE (Telefono #)

INSURED'S NAME - GUARANTOR (Nombre de Esposo(a)) EMPLOYED BY (Empleado Por) EMPLOYER'S ADDRESS (Dirección de Patron) BUS. PHONE (Telefone Emleo)

INSURED'S OCCUPATION (Ocupacion de Esposo/Esposa) INSURED'S DATE OF BIRTH (Fecha de Nacimiento de Esposo) INSURED'S SOCIAL SECURITY NUMBER (Seguro Social # de Esposo)

PHARMACY _____ PCP _____ REFERRED BY _____

Have you ever been involved in a lawsuit with another Doctor? ❑ Yes ❑ No

GENDER: ❑ Male ❑ Female **PREFERRED LANGUAGE:** ❑ English ❑ Spanish

RACE: ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacfic Island ❑ Asian ❑ Patient Declined ❑ State Prohibited ❑ Unspecified

ETHNICITY: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Patient Declined ❑ State Prohibited ❑ Unspecified

I have read this office's policy statement and understand that I am responsible for payment of all charges incurred on behalf of myself and my family regardless of insurance. (He leido poliza de esta oficina y entiendo que yo soy responsible de pagar todos los cargos mios y de mi familia aunque tenga seguro.)
I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of Dr. _____, his/her assistants or his/her designee as is necessary in his/her judgement.
I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me to the result of treatments of examination by Dr. _____.

I authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to the undersigned physicians or clinic. This will also serve as authorization for this office to obtain insurance information from Medicare or any other insurance regarding any claims submitted in my behalf. **Ray Graf, M.D., F.A.C.C., F.S.C.A.I., Charles J. Schechter, M.D., F.A.C.C., F.S.C.A.I., Stephen A. Turner, M.D., F.A.C.C., Gregg L. Silverman, M.D., F.A.C.C., Srikanth Damaraju, M.D., F.A.C.C., F.S.C.A.I., Shamim Badruddin-Mawji, M.D., F.A.C.C., Rafael Berio-Muñiz, M.D., F.A.C.C., Travis Taylor, M.D., F.A.C.C., F.S.C.A.I., 613 Elizabeth, Suite 102, 402, 402A, 411, Corpus Christi, Texas 78404; 13725 NW Blvd., Ste. 180, Corpus Christi, Texas 78410.**

Yo autorizo que se de la informacion medica para procesar este reclamo y requiere que el pago del seguro se haga directamente a el doctor o clinica abajo mencionados. Esto tambien servira como autorizacion para que esta oficina obtenga informacion de seguro de Medicare u otro seguro acerca de cualquier reclamo mandado a mi nombre. **Ray Graf, M.D., F.A.C.C., F.S.C.A.I., Charles J. Schechter, M.D., F.A.C.C., F.S.C.A.I., Stephen A. Turner, M.D., F.A.C.C., Gregg L. Silverman, M.D., F.A.C.C., Srikanth Damaraju, M.D., F.A.C.C., F.S.C.A.I., Shamim Badruddin-Mawji, M.D., F.A.C.C., Rafael Berio-Muñiz, M.D., F.A.C.C., Travis Taylor, M.D., F.A.C.C., F.S.C.A.I. 613 Elizabeth, Suite 102, 402, 402A, 411, Corpus Christi, Texas 78404; 13725 NW Blvd., Ste. 180, Corpus Christi, Texas 78410.**

I am the individual to whom the information/record pertains, or am authorized to consent, on behalf of the individual, to the release of the information/record. I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000, or one year in prison or both.

Yo soy la persona a la que le pertenece la informacion o expediente, o, estoy autorizado por esta persona para permitir que se de a conocer la informacion o el expediente. Yo entiendo que cualquier representacion falsa con conocimiento e intencion para obtener informacion del expediente de seguro social es castigable con una multa de no mas de $5,000, o un ano de prision o ambas.

PATIENT'S SIGNATURE (1) *Firma Del Paciente (1)* DATE *Fecha*

INSURED'S SIGNATURE (1) *Firma Del Asegurado (1)* DATE *Fecha*

COASTAL CARDIOLOGY, PLLC

PATIENT HISTORY FORM

NAME _____ DOB_____ AGE_____ SEX_____

DATE_____ SOCIAL SECURITY #_____ ACCT. # _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

Chest Pain:

Site of pain _____

Severity of pain _____

Type of pain _____

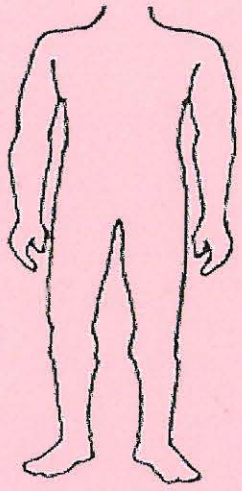
Time of pain _____

Associated factors _____

Aggravating factors _____

Radiation _____

Relieving factors _____



SOCIAL/PERSONAL HISTORY:

Marital Status (please circle): Married Widowed Single Divorced

Who lives in your household?:_____

Highest Education: _____ Occupation: _____

Tobacco Use: Yes _____ No_____ Never _____ How many packs per day _____

At what age did you first start smoking? _____ When did you quit smoking? _____

Alcohol Use: Type _____ Drinks per day, week, or month:_____

Drug Use (past and present): _____

DRUG or FOOD ALLERGIES: (Please list and give description of reaction)

Drug/Food	Reaction	Drug/Food	Reaction
_____		_____	
_____		_____	
_____		_____	

Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____

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NAME_____ ACCT. #_____ DATE: _____

MEDICATIONS: (Please list all medicines you are taking. Include over-the-counter, herbal, vitamins, etc. If additional space needed please ask for another sheet.)

Name	Strength or Color	How many times a day

FAMILY HISTORY: (Please use the following list to provide your families health history. List all diseases they have and at what age they were first diagnosed. If deceased, please state and give age or year of death.)

None	Cancer (Where?)	Epilepsy	Asthma	Bleeds Easily
Diabetes	Heart Disease	Stroke	Kidney Disease	Other:
Heart Attack	Hypertension	Anemia	Emotional Disorder	

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Mother's parents: _____

Father's parents: _____

PAST MEDICAL HISTORY: (Please list current and past medical problems, as well as hospitalizations and surgeries. Include approximate dates of when these occurred.)

Problem/Surgery	Date

Comments:

Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____

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NAME _____ ACCT. # _____ DATE: _____

REVIEW OF SYSTEMS: (Please circle yes or no next to the symptom(s) or disease(s) you have experienced in the past or present)

	CONSTITUTIONAL	Y N	NASAL CONGESTION	Y N	WHEEZING
Y N	FEVER	Y N	DOUBLE VISION		
Y N	WEIGHT LOSS	Y N	TRAUMA		**CARDIOVASCULAR**
Y N	WEIGHT GAIN	Y N	INFECTIONS	Y N	CHEST PAIN/DISCOMFORT
Y N	SLEEP PROBLEMS	Y N	CATARACTS	Y N	IRREGULAR HEART BEAT
Y N	FATIGUE			Y N	HEART ATTACK
Y N	APPETITE CHANGES		**RESPIRATORY**	Y N	SHORTNESS BREATH EXERTION
		Y N	SHORTNESS OF BREATH	Y N	HEART FAILURE
	HEENT	Y N	COUGH	Y N	SHORTNESS BREATH LYING DOWN
Y N	GLAUCOMA	Y N	PNEUMONIA	Y N	HIGH BLOOD PRESSURE
Y N	RINGING IN EARS	Y N	EMPHYSEMA	Y N	HEART MURMUR
Y N	DEAFNESS	Y N	BLOODY COUGH	Y N	SWELLING LEGS/ANKLES
Y N	VISUAL PROBLEMS	Y N	TUBERCULOSIS	Y N	FAINTING SPELLS
Y N	TROUBLE SWALLOWING	Y N	ASTHMA	Y N	SHORTNESS BREATH AFTER FALLING ASLEEP
Y N	HOARSENESS	Y N	CHRONIC BRONCHITIS	Y N	LEG/FOOT PAIN WHILE WALKING

	MUSCULOSKELETAL		**NEUROLOGICAL**	Y N	NERVOUS BREAKDOWN
Y N	GOUT	Y N	HEADACHES		
Y N	MUSCLE WEAKNESS	Y N	DIZZINESS		**ENDOCRINE**
Y N	TROUBLE WALKING	Y N	FAINTING	Y N	HEAT/COLD INTOLERANCE
Y N	JOINT SWELLING	Y N	WEAKNESS OF ARMS/LEGS	Y N	EXCESSIVE THIRST
Y N	ARTHRITIS	Y N	NUMBNESS OR TINGLING	Y N	EXCESSIVE URINATION
Y N	JOINT STIFFNESS	Y N	TROUBLE WALKING	Y N	GOITER
		Y N	MEMORY LOSS	Y N	THYROID DISEASE
	GENITOURINARY	Y N	STROKE	Y N	DIABETES
Y N	PAINFUL URINATION	Y N	SEIZURES/CONVULSIONS		
Y N	DISCOLORED URINE				**ALLERGIC/IMMUNOLOGIC**
Y N	TROUBLE URINATING		**GASTROINTESTINAL**	Y N	RASHES
Y N	KIDNEY DISEASE	Y N	ABDOMINAL PAIN	Y N	ALLERGY SHOTS
Y N	VENEREAL DISEASE	Y N	NAUSEA/VOMITING	Y N	BLOOD TRANSFUSION REACTION
		Y N	BLACK/BLOODY STOOLS		
	HEMATOLOGICAL/LYMPHATIC	Y N	CONSTIPATION/DIARRHEA		**FEMALES ONLY**
Y N	ANEMIA	Y N	JAUNDICE	Y N	HOT FLASHES
Y N	EASY BRUISING	Y N	INDIGESTION/HEARTBURN	Y N	MENOPAUSE
Y N	CANCER	Y N	HEPATITIS		DATE:
Y N	BLEEDS EASILY	Y N	GALLBLADDER DISEASE	Y N	HYSTERECTOMY
Y N	SICKLE CELL DISEASE				
Y N	HEMOPHILIA		**PSYCHIATRIC**		
		Y N	TROUBLE SLEEPING		
		Y N	DEPRESSION		
		Y N	ANXIETY		

Reviewed by: _____ Date: _____
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24 Hour Cancellation & "No Show" Fee Policy for Office Appointments

Coastal Cardiology PLLC is committed to providing the highest level of quality medical care and personal services to our patients. For every commitment there is an obligation. We feel it's the patient's responsibility to meet their obligation of his or her scheduled appointment.

Coastal Cardiology PLLC has established this policy to help Coastal Cardiology PLLC serve you better. We understand that situations arise in which you must cancel or reschedule your appointment(s). Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Coastal Cardiology PLLC Physician's reserves the right to charge a fee of $25.00 for all missed appointments that are not cancelled within 24 hours advance notice from your scheduled appointment. **Without the proper notification you may be subject to a $25.00 cancellation fee.**

Patients who do not show up for his or her appointment without a call to cancel will be considered a NO SHOW: therefore, a NO SHOW fee will be subject to a fee of $25.00

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No Shows" in a 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy

_____ _____

Signature of Patient Date

_____

Print Name

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PATIENT FINANCIAL RESPONSIBILITY FORM

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand I am financially responsible for my health insurance deductible, coinsurance, or any non-covered service.
- Co-payments are due at time of service.
- Previous Balances are due at your next office visit. If you are unable to pay the previous balance, you must speak with our Billing Office to set up a payment plan. Payment plans are 10% of your balance paid monthly via credit card.
- If your insurance plan requires a referral, you must be an established patient with your insurance appointed Primary Care Physician. This allows us to obtain referrals prior to your visit. There may be times when we ask you to help us obtain your referral.
- In the event your health plan determines a service to be "not payable," you will be responsible for the complete charge and agree to pay the costs of all services provided.
- If you are uninsured, all payments are due at the time of service.
- **COORDINATION OF BENEFITS (COB)** is when a person has health care coverage under more than one plan. It is the responsibility of the patient to make sure the insurance carrier knows which insurance plan is primary. Failure to keep your COB updated can result in the patient being responsible for the denied claims.

X _____ _____

Patient Signature, Authorized Representative or Responsible Party — Date

_____ _____

Printed Name, Authorized Representative or Responsible Party — Relationship

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TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting **Coastal Cardiology PLLC at 361 887-2900.**
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/ audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____
Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____
Witness Signature Date