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Trieu Ho, MD, FACC, FHRS
Clinical Cardiac Electrophysiologist

Last Name: _______________________ First Name: ________________________ Middle:___________

Date of Birth: _____________________Social Security Number: __________________________

Driver's License Number: ______________________ Sex: M F Marital Status: M S W D

Mailing Address: ____

City: _______________________________________State: ___________ Zip: ______________

Home Number: _________________ Cell Number: __________________ Work Number: ____________

Email: ____

Leave Voice Message? Y N Leave Text Message? Y N Leave Texts and Voicemails In:
Morning Afternoon Evening

Race: African American Asian Hispanic Indian White Other Language: English Spanish

Referring Cardiologist: ____

Referring Primary Care: ____

Occupation: ________________________ Employer's Name: ____________________________

Employer's Address: ______________________________ City: _________ State: _______ Zip: ______

Emergency Contact Name: _______________________________________

Relationship: ______________ Emergency Contact's Home Number: ______________ ____________

Emergency Contact's Work Number: _____________ Emergency Contact's Cell Number: _____________

Pharmacy Name: __________________________ Pharmacy City / Phone: _________________________

Ownership Disclosure: In the event you and your physician choose the Baylor Scott & White The Heart Hospital – Plano (HHBP), Baylor Scott & White The Heart Hospital – Denton/McKinney for your cardiovascular care, the HHBP is the first and only freestanding, full-service hospital dedicated solely to heart and vascular care in North Texas. It was created through a partnership between Baylor Regional Medical Center at Plano and cardiovascular specialists including your physician. This notice is to inform you that through this partnership, your physician has a financial ownership interest in the at these hospitals.

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INSURANACE INFORMATION

Primary Insurance Company: ____________________Policy Number: _________________________
Group Number: ________________________ Subscriber's Name: ______________________

Date of Birth: __________________________ Social Security Number: ______________________

Secondary Insurance Company: ____________________Policy Number: _________________________

Group Number: ________________________ Subscriber's Name: ______________________

Date of Birth: __________________________ Social Security Number: ______________________

In your own words, why are you here to see us today?

____

____

Do you have any medical problems? (Circle those that apply): None

Atrial fibrillation Atrial flutter Supraventricular tachycardia (SVT) Syncope

Premature ventricular contraction (PVC) Hypertension Diabetes (type I or type II) Stroke

Heart Disease CHF tachycardia Heart Attack Palpitation

Angina Peripheral Vascular Disease Valve Replacement or Repair Pacemaker/ICD

Other: ____

ANY surgeries or other procedures? (Please list)

Procedure		Date	Where
Stent	Y N	_________	_______________________________________
Left Heart Cath	Y N	_________	_______________________________________
CABG	Y N	_________	_______________________________________
Pacemaker/ICD	Y N	_________	_______________________________________
Cardiac Ablation	Y N	_________	_______________________________________
Heart Valve	Y N	__________	_______________________________________
Other _________________	Y N	_________	_______________________________________

Please name all your medications ***WITH dosages and how often it's taken,*** including herbal supplements and vitamins. (or attach list).

Medication Name	*Dosage*	*How Taken*
________________________	________________	_______________________________________
________________________	________________	_______________________________________

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_______________________ _______________ _____________________________________
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Are you allergic to any medications? Yes No If yes, please list:

____

Social History

Do you smoke or have you ever smoked, e-ccigarettes? Yes No

If yes, how old were you when you started? _______ Stopped? _______

How many packs per day on average (when you were at your worst)? ____________

Do you drink alcohol? Yes No Have you ever? Yes No

What do you drink? ____________________ How many drinks per week? ________________________

Do you currently or have you ever used recreational (illicit) drugs? Yes No

If yes, which ones and for how long?

____

Family History

Father Alive or Deceased Cause of Death ___________________ Age _________

Mother Alive or Deceased Cause of Death ___________________ Age ________

Children? Yes No How Many? ________ Ages and Gender? _____________________________

Do any illnesses or heart disease run in your family? Please list. ______________________________

____

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PATIENT FINANCIAL POLICY

Thank you for choosing Premier Heart Center (PHC) as your healthcare provider. This office is committed to your health and successful treatment. Please understand that payment of your services is considered part of your treatment. We ask that you please read the following FINANCIAL POLICY and sign the forms prior to any treatment. **ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME THE SERRVICE IS RENDERED. IF OTHER ARRANGMENTS NEED TO BE MADE PLEASE SPEAK WITH THE RECEPTIONIST PRIOR TO YOUR VISIT. WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD.**

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

______(**initials**) I hereby give authorization of insurance benefits to be made directly to PHC for 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 to collection. I hereby authorize this healthcare provider to release information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

INSURANCE

_____ (**initials**) We do accept assignment on your insurance benefits. We must have your insurance information to do any insurance billing. In event that your insurance company does not pay, we reserve the right to transfer your balances to your responsibility. We will be happy to assist you by providing you with claim forms and an explanation of benefits from your primary insurance after your balance with us is satisfied. Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan. All copays and deductibles are due at the time of treatment unless prior billing arrangements have been made. If your insurance requires a referral, we request that you bring it with you at the time of your visit. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans. This assignment will remain in effect until revoked by me in writing. A copy of the Assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges. I hereby authorize Premier Heart Center to release all information necessary to secure payment.

MEDICARE GUIDELINES

_____(**initials**) I authorized any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information need for this or related to Medicare claims. I permit a copy of this request for payment of medical insurance benefits either to myself or the responsible party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

USUAL AND CUSTOMARY RATES

_____ (**initials**) Premier Heart Center is committed to providing the best treatment for our patients and we charge what is usually and customary for our area. You are responsible for the minor. Payments for services provided to minors is due at time of service.

FORMS COMPLETETION

_____ (**initials**) There will be a $10.00- $25.00 charge for items for which the physician and/or staff are required to complete including but not limiting the following items:

a. Letter of Medical Necessity
b. Family Medical Leave Forms
c. Disability Forms
d. Application for handicapped parking permits and/or license
e. Prior authorization of medications through an insurance company

Thank you for understanding out **FINANCIAL POLICY.** Please let us know if you have any questions or concerns. I have read the **FINANCIAL POLICY.** I understand and agree to this policy.

Patient Signature: ____ **Date:** __________________

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PATIENT RIGHTS

We make no distinction in the availability of services; the admission, transfer, or discharge of patients; or in the care we provide based on age, gender, disability, race, color, religion, or national origin. We recognize and respect the diverse backgrounds and cultures of our patients and make every effort to equip our caregivers with the knowledge and resources to respect each patient's cultural heritage and needs.
We are mindful that the populations we serve are becoming even more diverse. Accordingly, we are structuring more formal programs to ensure that Premier Heart Center (PHC) colleagues are equipped to meet these articulated commitments for multi-cultural competency in patient care. PHC respects the patient's right to and need for effective communication.
Each patient is provided with the opportunity to view or receive a copy of **PHC Patient Rights** and a **Notice of Privacy Practices.** These statements include the rights of the patient to make the following decisions:

Make decisions regarding medical care

The right to refuse or accept treatment

The right to informed decision making

The right to know and access the information in your medical records

Such statements, like those mentioned above, conform to all applicable state, and Federal laws including, but not limited to the **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HERINAFTER REFFERED TO AS HIPAA).**

We seek to involve patients in all aspects of their care, including giving consent for treatment and making healthcare decisions. Some of which may include managing pain effectively, foregoing or withdrawing treatment, and as appropriate, care at the end of life. PHC addresses the wishes of the patient in relation to end of life decisions. As applicable, each patient or patient representative, is provided with a clear explanation of care including, but not limited to diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, estimates of treatment cost, organ donation and procurement, and an explanation of the risks, benefits, and alternatives associated with available treatment options.

Patients have the right to request transfers to other facilities. In such cases, the patient is explained benefits, risks, and alternatives of the transfer. Patients are provided information regarding their right to designation of surrogate healthcare decision-makers. Patient advance directives or resuscitation measures are honored within the limits of the law and our organization's patient's rights. Each patient and his or her representatives are accorded appropriate confidentiality, privacy security, advocacy and protective services, opportunity for resolution of complaints, and pastoral care, or spiritual care.

Patients have the right to an environment that preserves dignity and contributes to a positive self-image. Patients are treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights, and involvement in their own care.

PHC facilities maintain procedures to support patient rights in collaborative manner which involves the facility leaders and others. These structures are based on policies and procedures, which make up the framework addressing both patient care and organizational ethics issues. These structures include informing each patient or, when appropriate, the patient's representative in advance of furnishing or discontinuing care.

Patients receive information about the person(s) responsible for their care, treatment, and services. Patient, and when appropriate, their families are informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes. Patients are involved as clinically appropriate in resolving dilemmas about care decisions.

Facilities maintain procedures for prompt resolution of patient grievances which include informing patients of their rights regarding the grievance process. PHC addresses the resolution of complaints from patients and their families. Patients have the right to refuse care, treatment, and services in accordance with the law and regulations. PHC facilities maintain an ongoing and proactive patient safety. All statistics involving patient safety and healthcare errors are reported. PHC colleagues receive training about patient rights to clearly understand their role in supporting their patients. We strive to promote total wellness through targeted health education and illness-prevention programs that improve the quality of life of our patients and our communities.

Acknowledgment of Patient Rights

I have read the NOTICE OF PATIENT RIGHTS and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Rights Notice.
My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Acknowledgment of Patient Responsibilities

I have read the NOTIVE OF PATIENT RESPONSIBILITIES and have had any questions answered by this office. I understand that by signing this for I acknowledge that have read the Patient Responsibilities Notice.
My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

______________________________________ _______________________________

Patient's Name (printed) **Date**

____

Patient's Signature (or guardian, if a minor)

ACKNOWLEDGEMENT OF PATIENT RESPONSIBILITIES

_____ (**initials**) I have read the **NOTICE OF PATIENT RESPONISBILITIES** and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Responsibilities Notice posted in all PHC locations. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

CONSENT FOR TREATMENT FORM

_____ (**initials**) I understand that I have presented myself to PHC for evaluation and/or treatment for my condition. I authorize and direct PHC to perform quality care upon me and understand that all options will be discussed prior to the administration of such treatment. I acknowledge that the practice of medicine is not exact science and that no guarantees have been made to me as an outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

FACSIMILE AUTHORIZATION FORM

_____ (**initials**) I the undersigned, authorize Premier Heart Center (PHC) to send/receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed. I may revoke this authorization by giving PHC five (5) days written notice. This revocation may be by facsimile transmission; however, a written copy of the revocation must be mailed to PHC as well.

_____ (**initials**) I acknowledge that PHC has provided me with the opportunity to view and read a written copy of their Notice of Privacy Practices.

_____ (**initials**) I acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS & CONSENT OF DISCLOSURE OF INFORMATION

_____(**initials**) I acknowledge that Premier Heart Center will disclose my Protected Health Information (PHI) to a family member, other relatives, close friends, or any other person I identify that directly relates to that person's involvement in my care.

Person(s) ________________________ Phone Number ___________________ Relationship__________________

Person(s)_________________________Phone Number ___________________Relationship__________________

Or

_____ (**initials**) I **OBJECT** to the disclosure of my **Protected health Information** to a family member, other relatives, close friends, or any other person.

_____ (**initials**) **SHARING OF INFORMATION FOR PURPOSE OF PAYMENT:** I acknowledge that PHC will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to) benefit determination and utilization review as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data ware houses, and billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including, but not limited to) the credentialing for ongoing operations for this office and any relevant processes, the credentialing processes, peer review, accreditation, and compliance with all federal and state laws.

COMMUNICATION AUTHORIZATION

_____ (**initials**) I acknowledge that Premier Heart Center may communicate with me via US mail, home phone, through the patient portal, on a cell phone and through text message.

Patient Signature: ____

Personal Representative Signature: _________________________________Relationship to Patient: ____________

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Medical Records Release Form

Authorization for use or Disclosure of Protected Health Information

Patient's Name: ____

Social Security Number: _______________________________DOB: ___________________________

Day time Phone Number: _______________________ Evening Phone Number: __________________

Address:____

City: ____________________ State: __________________________ Zip Code: _________________

I herby authorize ______________________________ to use or disclose my protected health information as indicated below to

Premier Heart Center: Phone: (682) 214-3486, Fax: (682) 214-3470

1. **Grapevine: 2020 W. State Hwy 114, Suite 130 Grapevine, Texas 76051**
2. **Alliance: 10840 Texas Health Trail, Suite 200 Fort Worth, Texas 76244**
3. **Decatur: 1713 S FM 51 Suite 103 Decatur, TX 76234**

Information to be released:

From & To Dates: _____________________________

__ Copy of complete medical records

__ Nuclear stress test, holter, device check, OP reports

__History and Physical/ Consultation reports

__Laboratory, X-rays, EKG, Echocardiogram

__ Other ____________________________________

Purpose of Disclosure:

__Changing Physician __Second Opinion

__Continuing Care __Legal

__At my (patient) request __Insurance

__Worker's Compensation __School

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

__ Substance Abuse (including alcohol/drug use)

__Mental Health

__Psychotherapy Notes

__HIV related information (including AIDS related testing)

Other:_________________________________

Signature of Patient or Legal Guardian___________________________________

Date_________________________

1. I understand that this authorization will expire two years from my last date of service. A photocopy of this form will be considered as valid as the original.
2. I understand that information used or discolored pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information.
3. My healthcare and payment or my healthcare will not be affected if I do not sign this form.
4. I understand that I will get a copy of this form after I sign it. Signing below I acknowledge that I have read and understand this Authorization.

Signature_______________________________ **Relationship**_________________________ **Date**_______

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Appointments Policy: Scheduled/Cancellation/ No Show

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. There are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged, FIFTY dollars ($50.00) fee; this will not be covered by your insurance company. If a patient is 15 minutes past their scheduled time, we will have to reschedule their appointment. Both situations are considered a No Show.** After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

1) Patient Refill Request Policy

At Premier Heart Center, our mission is to serve our patient with the best quality care available. To help us reach that goal we ask that you keep the following in mind when it is time to get your medications filled for the first time or when you request refills.

A) If your prescription requires our office visit to refill, please call us to schedule an appointment two weeks before your prescription runs out.
B) Once an order has been put in at the office, please allow at least 24-48 hours for the prescription to be ready at your pharmacy.
C) If your refill request has been submitted for 24-48 hours and you have not heard back from your pharmacy that your prescription is ready for pick up, please call the office to verify that the fax or electronic request made it through to your pharmacy.
D) Please allow 3-4 business days for some scheduled 2 medications (Controlled) to arrive at your pharmacy. Some of these controlled medications are only available to be picked up at the clinic. If you are not sure just ask your provider.

2) Account Balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their accounts and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

____________________________	________________________	________________
Printed Name	**Patient Signature**	**Date**