St David's Heart & Vascular

Patient Registration Form

(Please print or write legibly)

Last Name:______________________________ First:______________________________ MI:__________

Gender: ☐Male ☐Female Date of Birth:____________________ Social Security:____________________

Mailing Address:____ Apt. #:____________

City:____ State:____________ Zip:____________

Please check the preferred primary phone number:

☐Home Phone: (_____)-______________________ ☐Work Phone: (______)-______________________

☐Mobile Phone: (_____)-______________________ Email:______________________________________

Preferred Language:____________ Marital Status:________________ Race/Ethnicity:________________

Emergency Contact Person:________________________________ Relationship: ____________________

Primary Number: (______)-________________ Secondary Number: (______)-________________________

Primary Care Physician:____________________ Referring Physician:______________________________

Employer's Name:____________________________________ Occupation:__________________________

Employer's Mailing Address:____ Suite #:______________

City:____ State:____________ Zip:____________

Insurance

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance: ____________________________ Policy #____________________________________

Policy Holder's Name:___________________________ Policy Holder's Date of Birth: _____ /______ /________

Secondary Insurance: __________________________ Policy #____________________________________

Policy Holder's Name:___________________________ Policy Holder's Date of Birth: _____ /______ /________

Tertiary Insurance: ____________________________ Policy #____________________________________

Policy Holder's Name:___________________________ Policy Holder's Date of Birth: _____ /______ /________

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to St. David's Heart & Vascular, PLLC. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

____ ________________________________

Signature of Patient or Personal Representative **Date**

*****Financial acknowledgement for Private Pay Patients or Patients without Insurance*****

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

____ ________________________________

Signature of Patient or Personal Representative **Date**

St David's Heart & Vascular

Authorization for Release of Medical Records

Patient Name: ____

Date of Birth: ____________________ Social Security: ________________

Release Records to:

Name: Cardio Texas, PLLC
Address: 1015 E 32nd St Suite 508
Austin, TX 78705
Phone: 512-807-3140
Fax: 512-469-0192

I hereby authorize the release of my medical records, including all results and tests that may include the following data: drug, alcohol, and psychiatric treatment to the party noted above.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Disclosure.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will expire ninety (90) days from the date of my signature or as otherwise specified by date, event, of conditions as follows: ______________________________

______________________________ ____________________

Patient Signature Date

____

Cardio Texas – Witness

St David's Heart & Vascular

PATIENT CONSENT FORM
General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request a St. David's Heart and Vascular physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at St. David's Heart & Vascular, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Signature of Witnessing Employee	**Date**
Printed Name of Witnessing Employee	**Employee Job Title**