South Texas Cardiothoracic
& Vascular Surgical Associates, PLLC

Welcome! Thank you for selecting our healthcare team. We intend to provide you with the best possible healthcare. Please fill out this form to aid us in that effort. If you have any questions, please ask us—we will be happy to help.

Referred to our office by: _____

PERSONAL INFORMATION **TODAY'S DATE:** _____

Patient Name: _____

Address: _____ Telephone: _____

City/State: _____ ZIP: _____ Mobile Phone: _____

SS# _____ Date of Birth: _____ Age: _____ Sex: M or F

Marital Status: Single Married Divorced Widowed **E-mail Address** (optional): _____

Employer: _____ Address: _____

Occupation: _____ Work Phone: (____)_____-_____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Date of Birth: _____ Spouse's Occupation: _____ Work Ph: (____)_____-_____

Patient's/Responsible Party's Driver's License # & State: _____/____ SS#: _____-____-_____

Person to Notify in an Emergency: _____ Relationship: _____

Telephone: (____)_____-_____ Additional Telephone(s): (____)_____-_____/(____)_____-_____

Cardiologist: _____ Telephone: (____)_____-_____

Primary Care Physician: _____ Telephone: (____)_____-_____

Pulmonologist: _____ Telephone: (____)_____-_____

INSURANCE INFORMATION

Medicare #: _____ **Medicaid #** _____

Primary Insurance Company: _____ Telephone: (____)_____-_____

Address: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____

Date of Birth of Insured: _____

Secondary Insurance Company: _____ Telephone: (____)_____-_____

Address: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____

- I hereby authorize South Texas Cardiothoracic & Vascular Surgical Associates, PLLC, to release medical information to my insurance companies and other healthcare providers involved in my care. I authorize payment of surgical & medical benefits directly to South Texas Cardiothoracic & Vascular Surgical Associates, PLLC. I understand that I am personally responsible for all charges not covered by this authorization and I hereby guarantee payment of this account.

Signature: _____ Date: _____

PLEASE COMPLETE ENTIRE FORM

SOUTH TEXAS CARDIOTHORACIC AND VASCULAR SURGICAL ASSOCIATES

Our Financial Policy

Thank you for choosing South Texas Cardiothoracic and Vascular Associates (STCVSA) as your health care provider. We are committed to providing you the highest quality and most efficient cardiothoracic and vascular surgical care. Payment of your bill is considered part of our relationship. We accept most insurance plans. If you have medical insurance, we stand ready to assist you in receiving your maximum allowable benefits. In order to do so, we need your help by understanding this statement of our Financial Policy.

Except in emergencies, patients must complete our Information / Insurance form before seeing the doctor.

FULL PAYMENT is DUE ON THE DAY OF SERVICE unless you are enrolled in an insurance plan in which STCVSA participates.

CO-PAYMENTS & DEDUCTIBLES for all insurance plans must be paid at the time of service. Failure to pay co-pays will be reported to your insurance plan and/or your employer. Co-pays are condition of your insurance coverage, and you may be subject to termination of your insurance benefits if you do not pay them.

METHOD of PAYMENT: CASH, CHECK, MASTERCARD, and VISA are accepted when you are in our office, and credit cards are accepted over the phone.

INSURANCE COVERAGE as health care providers, our relationship is primarily with you, not your insurance company. As a courtesy and convenience to you, we file insurance claims for all our patients. We cannot bill your insurance company unless you give us your current, accurate insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you have problems or are uncertain about insurance, PLEASE ask for help. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your personal balance. Please be aware that some of the services provided may be non-covered services or not considered reasonable or necessary under the Medicare program and/or other medical insurance.

STATEMENTS are sent out once a month for any outstanding balance. Personal balances are due upon receipt of the statement. You may be assessed a handling fee for each additional bill we must send to you to obtain payment. Please advice us if any changes in your address or insurance coverage. Monthly statements returned due to a wrong address may be sent to a collection agency.

REFUNDS: If your account has a credit balance, we will write you a refund check as soon as possible, usually within 10 working days.

OVERDUE ACCOUNTS are a problem for everybody involved, and therefore are discouraged. You may be assessed a $15.00 fee for any account overdue more than 90 days and sent to an outside collection agency.

NON-SUFFICIENT FUND CHECKS written to STCVSA will have a $30.00 fee added to the account. A letter will be sent to the patient requesting the check be made good. If no explanation or payment is received within 14 days, the account will be turned over to an outside collection agency. Subsequent services must be prepaid in cash until the account is paid in full.

USUAL and CUSTOMARY RATES for our area is what we charge, and STCVSA is committed to providing the best treatment for our patients. Unless we have a contract with an insurance company to the contrary, you are responsible for payments regardless of an insurance company's arbitrary determination of usual and customary rates. If you request, we will submit the charges to your medical insurance plan, however, if payment is not promptly received, you will be responsible. If the balance is not paid according to the rules of the financial policy, the account will be turned over to the collection agency.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns regarding the policy or any other STCVSA policies or procedures.

Signature: _____ Date: _____

South Texas Cardiothoracic
& Vascular Surgical Associates, PLLC

4330 Medical Drive, Suite 325
San Antonio, TX 78229

Phone: (210) 615-7700
Fax: (210) 615-1782
www.heartlungsa.com

COMPLETION OF PAPERWORK/FORMS

Our office DOES NOT complete any disability paperwork. Short term disability forms as well as long-term disability forms need to be completed by your cardiologist, pulmonologist, or PCP, as one of them will follow you long-term.

Our office WILL complete FMLA forms. There is a pre-paid fee of $25.00 for FMLA completion. FMLA will be completed within 10 days of receipt.

There is a $25.00 fee for release of medical records.

Patient's printed name AND signature **Date of Birth**

Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed 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.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority, if applicable

Please complete the following: **Any information we gather will be kept confidential.** PRINT AND USE INK. Thank you.

Patient Name: _____ **Date:** _____

Why have you come to the doctor? When did it start; symptoms; prior treatments?

_____

_____

_____

Do you have any allergies? Yes No

List all allergies and describe your reaction: _____

_____

_____

_____

PAST MEDICAL HISTORY: Please circle all illnesses or conditions below that you have:

Bleeding problems	High Blood Pressure	Thyroid
Psychological/Psychiatric	Stroke/seizure	Diabetes
Heart attack, Stents, CABG	Atrial Fibrillation	

List your past hospitalizations (include the reason and the date):

_____

_____

_____

_____

_____

_____

List your previous surgeries (include the reason and the date):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family History:

Diabetes Heart trouble Stroke Atrial Fibrillation Cancer

High Blood Pressure

Version: August 19, 2008

List your CURRENT MEDICATIONS include prescription, over-the-counter and herbs:

Name of Medicine	Dose	Frequency	Reason for Taking this	How long have you used this

Do you Smoke? Yes No

Do you use street drugs? Yes No

Do you drink alcohol beverages? Beer Wine Liquor

In general would you say your health is: Excellent Very Good Good Fair Poor

How many flights of stairs can you climb? None Less than one One Two More than two

You walk with: No help Cain Walker Wheelchair

What type of work have you done all your life: _____?

_____

_____

_____

Current occupation: _____

Review of Systems: **Check all that you have had or have now:**

General:
None Other:
Fever or chills
Sweats
Change in Sleep Patterns
Fatigue
Weight Gain or Loss

Neurologic:
None Other:
Memory changes
Numbness or tingling

Dizziness or fainting
Weakness
Blurred vision
Headache
Hearing problems
Stroke

Lungs:
None Other:

Asthma
Emphysema
Oxygen use

Heart:
None Other:
Heart Attack
Stents
Heart Cath.
Bypass surgery
Palpitations
Atrial fibrillation
Pacemaker
AICD
Slow heart rate

Gastrointestinal:
None Other:
Hepatitis
Ulcers
Gallbladder problems
Bleeding
Diarrhea
Nausea or Vomiting
Heart burn or reflux
Cramping or stomach pain

Genitourinary
None Other:
Blood in urine
Prostate problems
Urination problems

Skin:
None Other:
Rashes
Change in mole
Bruises or bleeding

Endocrine:
None Other:
Temperature intolerance Hot Cold
Thyroid problems
Diabetes Diet Control Insulin
Adrenal problems

Psychological:
None Other:
Worried or anxious
Sad or depressed
Mood swings