Texas Cardiology Associates of Houston

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Kingwood, TX 77339
(281) 358-1950
(281) 358-1923 fax

Cardiology
Interventional Cardiology
Board Certified

4331 Brightwood, Ste. 203
Houston, TX 77068
(281) 440-7373

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PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I.:____

Social Security #:_____ Date of Birth:_____ Sex:____M ____F

Marital Status: ____Married ____Single ____Divorced ____Widowed ____Separated Birth Place:_____

Race: ____Declined ____White ____Black/African American ____Native Hawaiian ___Asian
____American Indian/Alaska Native ____Other Pacific Islander ____More than 1 race

Ethnicity: ____Hispanic/Latino
____Not Hispanic/Latino
____Decline

Preferred Language:_____English _____Spanish ___Other:_____

Address:_____

City:_____ State:_____ Zip:_____

E-mail:_____ Drivers License #:_____

Referring Doctor:_____ Primary Care Physician:_____

Home #:_____ Cell #:_____ Work #:_____

Employer Name:_____ Employer Phone #:_____

What is the best number to be reached at? ___Home ____Cell ____Work
May we contact you by e-mail? ____Yes ____ No ***May we contact you at work?*** ____Yes ____ No

PRIMARY INSURANCE

Primary Insurance:_____ Insurance Phone #:_____

Insured Last Name:_____ Insured First Name:_____ M.I.:____

Insured Social Security #:_____ Insured Date of Birth:_____ Sex:____M ___F

Policy #:_____ Group #:_____

Relationship to Patient:_____ Insured Employer:_____ Employer Phone #:_____

*******Please initial here if you do not have secondary insurance*** ____ *********

SECONDARY INSURANCE

Secondary Insurance:_____Insurance Phone #:_____

Insured Last Name:_____ Insured First Name:_____ M.I.:____

Insured Social Security #:_____ Insured Date of Birth:_____ Sex:____M ___F

Policy #:_____ Group #:_____

Relationship to Patient:_____ Insured Employer:_____ Employer Phone #:_____

PHARMACY & EMERGENCY CONTACT INFORMATION

Pharmacy Name:_____ Pharmacy Phone #:_____

Pharmacy Address:_____

Emergency Contact Name:_____Relationship: _____

Home #: _____ Cell #:_____ Work #: _____

Name of family member not living with you:_____Relationship:_____

Home #:_____ Cell #:_____ Work #: _____

FINANCIAL POLICIY

******It is our office policy to inform you of our policies. Please review and initial both sections below******

Patients with Insurance: You are responsible for deductibles, copays, coinsurance, non-covered services and any services deemed "not medically necessary" by your insurance company. Please pay copay and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. Unpaid balances are subject to debt collection through an outside collection agency.

Workers Compensation Patients: We do not accept workers compensation

Self Pay Patients: Payment is due at time of service

Medicare Patients: Our office will submit your charges to Medicare and your secondary insurance. You are responsible for any deductibles, copays, coinsurance and non-covered services at time of service.

Referrals: If your insurance carrier requires a referral from your primary care/POS (point of service) physician for treatment by a specialist, it is your responsibility to obtain the referral. Failure to obtain a referral will result in rescheduling of your appointment until such time as a referral is received. If you wish to obtain services without a referral, you will be required to sign a waiver, which outlines your financial responsibility.

We accept cash, checks, Visa, Discover and MasterCard. If you are unable to make payments at each visit, please notify the front desk staff to make other arrangements.

☐ **Initial Here**

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payments directly to Texas Cardiology Associates of Houston and/or its physicians. I understand that I am responsible for any amount not covered by my insurance.

I hereby authorize Texas Cardiology Associates of Houston and/or its physicians to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims; (4) view health plan details and to appeal claims on the patients behalf; and (5) bill and receive payments directly from the insurance carrier. This order will remain in effect until revoked by me in writing.

I have requested medical services from Texas Cardiology Associates of Houston and/or its physicians on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

☐ **Initial Here**

I have read and agree to the Financial Policy and Assignment of Benefits/Release of Information paragraphs stated above that apply to me.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Print Name if Signing on Behalf of Patient Reason Patient Can't Sign

_____ _____ _____

Relationship to Patient Address Phone #