MANISH PATEL, MD, FACC, FSCAI

Phone : (214)-884-7525 **Fax : (214)-884-7551**

☐ **2727 Bolton Boone Dr., Ste 112**
Desoto, TX 75115

☐ **221 Regency Parkway, Ste 105**
Mansfield, TX 76063

Welcome to Precision Cardiac and Vascular Care. Please bring the following iteams with you for your appointment.

- Picture ID
- Insurance Card(s)
- Completed New patient Registration Forms
- All medication you are currently taking (pl. bring the bottles if possible).
- Referral from Primary care physicians, if required by your insurance plan and contact information of the referring physician. (Important: If your insurance require a referral from your primary care physician, you must have the referral with you in order to be seen by physician; otherwise, your appointment will have to be re-scheduled.)
- Your Pharmacy name and telephone number
- Any medical records that pertain to your visit.
- If you are unable to keep your appointment, it is very important to inform us 24hrs in advance in order to avoid any cancellation fees.
- We have multiple locations. Your appointment location is marked above.

If you have any question, please feel free to call us at 214-884-7525.

Thank you for choosing Precision Cardiac and Vascular care for your Cardiology Care.

PRECISION
CARDIAC & VASCULAR CARE

Patient Registration Form

Phone : (214) 884-7525 , Fax : (214) 884-7551

Patient Information					
Last Name	First Name		Middle Initial		
Date of Birth	Social Security Number	Gender			
Street Address	Apt.	City	State	Zip	
Patient Employer	Work Number				
Home Phone	Cell Phone or Other				
Emergency Contact Name	Emergency Contact Number	Relationship			
Referring Provider (This section MUST be completed for Insurance Purposes)					
Physician's Name	Phone Number				
Insurance Information					
Primary Insurance	Insurance Phone	Subscriber Name	Relationship		
ID Number	Group Number	Subscriber SS#	Date of Birth		
Address of Insurance (Street or P.O. Box, City, State Zip)					
Secondary Insurance	Insurance Phone	Subscriber Name	Relationship		
ID Number	Group Number	Subscriber SS#	Date of Birth		
Pharmacy Name, address & Telephone Number:					

Consent For E-Prescribing & Medication History: *I Understand that as a part of my electronic health record., Precision Cardiac and Vascular Care will transmit my prescription electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, Precision and Cardiac and Vascular Care will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit manager and I understand that those prescriptions will become a part of my electronic record. By signing below I hereby give consent to the above actions.*

*Signature of Patient*_____ *Date* _____

I hereby authorize Precision Cardiac and Vascular Care to perform medical services and bill my insurance company for services and the release of these reports requested by my physician or insurance company and/or to their designate(s) when necessary to process the claim for clinical review. Precision Cardiac and Vascular Care will send the claim to the listed insurance carriers as a courtesy. The policy holder or subscriber is responsible for understanding the parameters of their insurance (i.e.: In-network, out-of-network, deductibles, co-pays and if a pre-authorization is needed for ordered tests. If, for any reason, your insurance company does not cover any performed services, the subscriber is responsible for payment of outstanding balances. ***Thank You!***

Signature of Patient_____ ***Date*** _____

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Authorization Form For
Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below to family members or other persons of my choosing as designated on the document.

Patient Name: _____ **Date of Birth:** _____

My PREFERRED Method of Contact is:
(Check one that is PREFERRED & provide all additional contact information below)

_____ Telephone (Cell/Home/Work) My number is: _____

_____ Text Message. My number is:

_____ E-Mail. My e-mail address is: _____

Check all that apply below:
_____ It is O.K. to leave me a message with detailed information. _____ It is NOT O.K.

It is O.K. to contact me at work. My number is: _____

_____ It is O.K. to leave me a message at work with detailed information.

_____ It is NOT O.K. to leave me a message at work with detailed information

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

_____ My spouse, whose name is: _____ Phone: _____

_____ My parent, whose name is: _____ Phone: _____

_____ My child, whose name is: _____ Phone: _____

_____ No one other than myself

_____ Fill in any other name you desire: _____

_____ _____

Signature of Patient or Personal Representative **Date**

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Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____
Printed Name of the Patient

_____ _____
Signature of Patient or Responsible Party if a Minor Date

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Patient Agreement in Office Policies

"Our financial policy has been set up to prevent misuderstandings"

- I hereby agree to assign payments over to the office of Precision Cardiac and Vascular Care if my insurance carrier does not cover services, due to co-payments, deductible, co-insurance etc ....

- I realize that I am responsible for payment for any or of any treatments that my insurance carrier may not pay.

- **I am responsible for my $ deductible and co-payment which has been determined by my insurance. My co-payment and deductible will be paid at the time of the service, unless other arrangements have been made with the office. If insurance information is incorrect, I will be responsible for entire payment.**

- I understand that a $20.00 fee will be charged for all retutrned/bad checks and will terminate my privilege to pay by check on future vists.

- I understand and agree that in the event of any outstanding balance has to referred to a collection agency or attorney for recovery, I will be responsible for all collection and attorney's fees.

- Because your time is valuable, we will make every effort to being promptly. However, our time is equally as important and we expect that you be on time for scheduled appointments and give us 24 hours notice of any cancellation.

Please sign below to indicate that you have read and fully understand the policy.

_____ _____

Signature **Date**

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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

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Patient Information Sheet

Patient Name: _____ Date : _____

DOB : _____ Sex : _____ Age : _____

Referring Physician : _____ Reason for Visit : _____

Any Heart / Circulation Problems : Check all that apply :

____ Heat Attack ____ Congestive Heart Failure ____ Defibrillator (ICD)

____ Angioplasty/Stent ____ Arrhythmias / Irregular Heart Beat ____ Heart Valve Surgery

____ Bypass Surgery ____ Varicose Veins (Enlarged Leg Veins) ____ Heart Valve Disorder

____ Heart Murmur ____ Congenital Heart Disease ____ Arterial Fibrillation

____ Cardiomyopathy ____ PAD (Leg Artery Blockage) ____ Mitral Valve Prolapse

____ Pacemaker ____ Heart Cath / Angiogram

Pl. list any other heart conditions: _____

Other Medical Problem : Check all that apply :

____ Asthma ____ Pulmonary Embolism (Clot in Lungs) ____ Stomach Ulcer

____ Cirrhosis ____ PAD (Blockage in Leg Arteries) ____ High Blood Pressure

____ Anemia ____ Emphysema/COPD ____ Stroke /TIA

____ Diabetes ____ DVT (Leg Vein Clot) ____ Enlarged Prostate

____ Arthritis ____ High Cholesterol ____ Kidney Failure

____ Cancer ____ Thyroid Disorder

List Any Previous Operations or other medical problems : _____

Check all that apply :

Current Smoker _____ Smoked in the past _____ Alcohol Use _____ Illicit Drug Use _____

Family History of :	Father	Mother	Other	Sister
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____

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Peripheral Arterial Disease (PAD) Questionnaire

Peripheral Arterial Disease (PAD) is a condition in which the arteries that carry blood to the muscles of the legs become narrowed and hardened due to the buildup of plaque. It can result in leg pain or "fatigue," which can limit your physical activity. PAD can also increase your risk of having a heart attack or stroke if untreated.

1. Do you have any discomfort in the muscles of your legs when you walk that is relieved by rest ? ---------- YES NO
2. Do your legs every feel fatigued or heavy when walking or being active ? ---------- YES NO
3. Do you ever need to stop and rest when walking or have difficulty keeping up with others ? ---------- YES NO
4. Do your feet and toes bother you at night ? ---------- YES NO
5. Would you have difficulty doing any of the following because of leg fatigue, weakness, or discomfort ? ---------- YES NO

	No Difficulty	Some Difficulty	Unable
Walking one block	1	2	3
Climbing One flight of stairs ?	1	2	3
Walking at an increased pace ?	1	2	3

Venous Questionnaire

Disease of leg veins, such as varicose veins (Large bulging veins) or venous insufficiency (leaky leg veins) can cause pain, swelling, infections, and ulcers. These can be frequently treated by ablation or laser treatment.

Pl check if you have any of the following symptoms:

- Leg pain, aching, cramping : _____
- Burning or itching in the legs : _____
- "Heavy" feeling in legs : _____
- Leg swelling, especially towards end of the day : _____
- Varicose Veins : _____
- Skin discoloration or texture changes in legs : _____
- Open wounds or sores in legs : _____

Physician Notes :

Patient Name : _____