CARDIOLOGY AND TRANSPLANT ASSOCIATES

GENERAL CONSENT TO OBTAIN MEDICAL SERVICES

I hereby voluntarily give my consent for and authorize Cardiology and Transplant Associates to provide medical services to me (or to _____) ("Patient").

If signed by any person other than Patient: I hereby represent and warrant to Cardiology and Transplant Associates that I have the legal authority to make medical decisions for the Patient.

_____ _____

Patient's Name Signatory's Name (if not Patient)

_____ _____

Signature of Patient or Legally Responsible Person Date

CARDIOLOGY AND TRANSPLANT ASSOCIATES

FINANCIAL RESPONSIBILITY

I have requested certain medical services from Cardiology and Transplant Associates on behalf of myself or Patient, as applicable, and understand that by requesting these services I agree that:

1. All services rendered are charged to the Patient, unless other arrangements have been made in advance with our office; and

2. The Patient (or guarantor, if not the same person) becomes fully financially responsible for any and all charges incurred in the course of provision of said services and agrees to pay all such charges in full immediately upon receipt of the appropriate statement; and

3. Cardiology and Transplant Associates will bill Patient's insurance carrier as a courtesy, even though the Patient or guarantor is considered responsible for the charges when the services are rendered. In the event the insurance carrier does not remit payment within 90 days of receipt of the claim, the applicable balance will then be due from Patient or guarantor, as applicable; and

4. Unless insurance company has a contract with Cardiology and Transplant Associates to pay based on a negotiated fee schedule, Patient or guarantor may be responsible for any difference remaining between the insurance allowable and the total charges.

ASSIGNMENT OF BENEFITS

I hereby assign all medical insurance benefits to which Patient is entitled (as applicable to the services provided by Cardiology and Transplant Associates, its physician(s) and other qualified personnel) to Cardiology and Transplant Associates. I hereby authorize and direct insurance carrier(s), including, without limitation, Medicare and private insurance carriers, to issue payment(s) directly to Cardiology and Transplant Associates for medical services rendered to Patient.

AUTHORIZATION TO RELEASE INFORMATION

1. I hereby authorize Cardiology and Transplant Associates to release any and all information deemed necessary by insurance carrier(s) in order to process insurance claim(s) related to the services rendered to the Patient. I hereby authorize a photocopy of my signature to be used to process insurance claim(s). This authorization shall remain in effect until revoked by me in writing.

2. A photocopy of this document shall be considered as valid as the original.

If signed by any person other than patient: I hereby represent and warrant to Cardiology and Transplant Associates that I have the legal authority to make financial decisions for the Patient.

_____ _____

Patient's Name Signatory's Name (if not Patient)

_____ _____

Signature of Patient or Legally Responsible Person Date

CARDIOLOGY AND TRANSPLANT ASSOCIATES

NO-SHOW POLICY

1. Your appointment time is reserved for you. If you miss your appointment and do not cancel it at least 24 hours in advance by talking to one of the office staff members during business hours on a business day prior to your appointment day, you will be assessed a no-show fee for each missed appointment as follows: $25 for office visit (in person or by telemedicine), $50 for echocardiogram, $100 for cardiac catheterization and $200 for stress test. This no-show fee must be paid prior to scheduling any future appointments. If you are late 20 minutes or more for your in-person appointment or 10 minutes or more for your telemedicine appointment, we may not be able to accommodate you. Consequently, you may be considered to have missed your appointment, and the no-show fee may apply.

2. If you are scheduled for a stress test, we also purchase radiopharmaceuticals 1 day prior to your test. These radiopharmaceuticals decay (lose their properties) over time and can only be used on the day and time, for which they were purchased. Therefore, stress tests appointments must be confirmed by the patient (or authorized representative) personally at least 1 business day prior to the test or they may be cancelled. Please note that if we are unable confirm your stress test appointment, we are not obligated to cancel it, and you may still be assessed a no-show fee as specified in paragraph 1 above.

I have read this Policy, understand its contents and agree to comply with it.

_____ _____

Patient's Name Signatory's Name (if not Patient)

_____ _____

Signature of Patient or Legally Responsible Person Date

CARDIOLOGY AND TRANSPLANT ASSOCIATES

FINANCIAL POLICY

Commercial Insurance, Medicare and Medicaid

1. You must provide us with correct insurance information and notify us of any changes in your insurance information at the time of your visit. We may bill you for services not paid by your insurance within 90 days of the date the claim is filed.

2. We will accept the contract allowable fees as payment in full for the provided services, if we are participating providers with your insurance. However, we are not allowed by law to waive your copay and/or coinsurance. It is our policy to collect copays prior to your office visit. If you have insurance deductible, which is not met at the time of your visit, you may be required to pay the portion of the visit charges that will apply to your deductible at the time of your visit. If your account has a credit balance after your insurance pays all the claims, this balance will be refunded to you or applied to future charges at your discretion.

3. Occasionally services provided may not be covered by your insurance carrier. Payment for these services will be your responsibility.

4. We are a participating provider and accept assignment of Medicare benefits. However, Medicare does not pay for all charges, and you are responsible for your deductible and any difference between the amount allowed by Medicare and the amount paid by Medicare and secondary insurance, if applicable.

5. WE DO NOT PARTICIPATE IN THE MEDICAID PROGRAM.

Returned Checks, Patients with Balances

1. If your check is not honored by your financial institution, our bank will charge us a fee. We will charge you a fee on every returned check, which will be the fee assessed to us or the maximal amount allowed by law, whichever is less.

2. If you are unable to pay your balance in full, we may at our discretion make reasonable payment arrangements with you. However, if you do not establish or do not follow your established payment arrangement, and your account has a balance more than 90 days past due, you will have to pay your balance in full prior to your next office visit. Additionally, your account may be referred to an outside collection agency, in which case you will be assessed a collection fee up to the maximum amount allowed by law in addition to the balance on your account.

I have read this Policy, understand its contents and agree to comply with it.

_____ _____

Patient's Name Signatory's Name (if not Patient)

_____ _____

Signature of Patient or Legally Responsible Person Date

CARDIOLOGY AND TRANSPLANT ASSOCIATES

PRIVACY FORM

Please list person(s) (e.g., family, friends, and other physicians) with whom we may share your information

Name	Relationship

Please list person(s), who we may contact in case of emergency or if we are unable to contact you

Name	Relationship	Telephone

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize Cardiology and Transplant Associates, its physician(s) and other authorized personnel to obtain prescription history electronically, as may be required in the course of evaluation and/or treatment of the Patient.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed or reasonably have had an opportunity to review Cardiology and Transplant Associates' Notice of Privacy Practices (available on www.ctahouston.com/forms), which explains how medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document, if I so desire.

_____ _____

Patient's Name Signatory's Name (if not Patient)

_____ _____

Signature of Patient or Legally Responsible Person Date

CARDIOLOGY AND TRANSPLANT ASSOCIATES

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE FORM

Patient's Name _____ Medicare ID _____

I request that payment of authorized Medicare benefits be made on my behalf to Cardiology and Transplant Associates for any services furnished to me by Cardiology and Transplant Associates, its physician(s) and/or other authorized personnel. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its successor(s), agent(s) and/or designee(s) any information reasonably required to determine the benefits payable for related services.

I understand that by affixing my signature below I request that payment be made on my behalf (or on behalf of Patient) to Cardiology and Transplant Associates and authorize release of medical information necessary to pay such claim(s). If health insurance provider other than Medicare is indicated on approved claim form(s) or electronically submitted claim(s), by affixing my signature below I authorize releasing of the relevant information to the insurer or agency shown.

_____ _____

Patient's Name Signatory's Name (if not Patient)

_____ _____

Signature of Patient or Legally Responsible Person Date

CARDIOLOGY AND TRANSPLANT ASSOCIATES

CONSENT TO LEAVE DETAILED VOICEMAIL

Cardiology and Transplant Associates (CTA) staff may contact you by telephone for appointment confirmations, medication adjustments, and/or other instructions. CTA staff can leave detailed medical information on your voicemail with your consent.

By signing this Consent to Leave Detailed Voicemail, you authorize CTA to leave voicemail messages containing detailed medical information (Detailed Voicemail) on the phone number(s) we have on file. This information may include, but is not limited to, demographic information (partial or full name, date of birth, address, etc.), appointment confirmations, billing information, medical information (diagnosis, medications, test results, etc.).

IF YOU DO NOT CONSENT TO US LEAVING DETAILED VOICEMAIL, PLEASE INITIAL BELOW

_____

I understand that CTA cannot require me to sign this consent form in order to receive treatment.

I understand that I have the right to revoke this consent at any time by sending a written request to Cardiology and Transplant Associates. This consent shall be valid until such revocation is received by CTA. My decision to revoke this consent will not apply to any information disclosed prior to the date the request to revoke this consent is received by CTA.

I understand that I am entitled to a copy of this completed consent form.

_____ _____

Patient's Name Signatory's Name (if not Patient)

_____ _____

Signature of Patient or Legally Responsible Person Date

Cardiology and Transplant Associates

New Patient History Form

Name: _____

Today's date:_____ Date of Birth: _____

Marital Status: (please circle) S M W D

Were you referred to us by another doctor? *(if yes, please specify below)* Yes / No

Name:

Address:

Phone: *Fax:*

Why are you seeing us today? _____

Medical History (please circle):

Do / Did you have any heart disease? *(if yes, please specify below)* Yes / No

Do / Did you have high blood pressure? Yes / No

Do / Did you have diabetes? Yes / No

Do / Did you have abnormal cholesterol? Yes / No

Do / Did you have aortic aneurysm or dissection? Yes / No

Do/Did you have a stroke or mini stroke (TIA)? Yes / No

Do / Did you have kidney disease? Yes / No

Other chronic conditions? *(if yes, please specify below)* Yes / No

Surgeries *(if yes, please specify below)* Yes / No

Social History (please circle):

Do / Did you smoke/chew/dip? *(if yes, please specify below)* Yes / No

packs/day: # years: Year quit:

Do / Did you drink alcohol? *(if yes, please specify below)* Yes / No

drinks/week: # years: Year quit:

Do / Did you use street drugs? *(if yes, please specify below)* Yes / No

Year quit:

Do you have a family history of (please circle):

Heart attack **at a young age** (<55 for male, <65 for female relatives)? Yes / No

Heart failure (weak heart) **at a young age**? Yes / No

Sudden death? Yes / No

Aortic aneurysm? Yes / No

Marfan's syndrome? Yes / No

Heart disease at birth? Yes / No

Other diseases? *(if yes, please specify below)* Yes / No

Allergy to latex? Yes / No

Allergies to medications? *(if yes, please specify)* Yes / No

Please list all medications you are currently taking:

Pharmacy _____

Phone _____

Have you ever had any of the following?

Chest discomfort or pressure Yes / No

Chest discomfort with activity Yes / No

Shortness of breath with activity Yes / No

Waking up at night short of breath Yes / No

Shortness of breath when lying flat Yes / No

Swelling of feet Yes / No

Waking up at night to urinate Yes / No

Irregular heart beat/palpitations Yes / No

Fainting spells Yes / No

Dizziness/near-fainting (please circle) Yes / No

Pericarditis Yes / No

Heart murmur Yes / No

Enlarged heart Yes / No

Rheumatic fever Yes / No

Exertional leg discomfort Yes / No

Cough or bloody sputum (please circle) Yes / No

Wheezing Yes / No

Tuberculosis (TB) Yes / No

Stomach or duodenal ulcer (please circle) Yes / No

Gastrointestinal bleeding Yes / No

Liver disease or hepatitis Yes / No

Discomfort when urinating Yes / No

Recurrent miscarriages Yes / No

Weight loss or gain (please circle) Yes / No

Heat or cold intolerance (please circle) Yes / No

Blood clots in legs (DVT) or lungs (PE) (please circle) Yes / No

Bleeding or easy bruising (please circle) Yes / No

Convulsion/seizure Yes / No

Vision problems Yes / No

Hearing problems Yes / No

Depression/excessive worry Yes / No

Persistent or recurrent muscle/joint pain Yes / No

Cancer *(if yes, please specify below)* Yes / No

Other *(if yes, please specify below)* Yes / No

Reviewed by/date: _____