CARDIOVASCULAR &

HEART FAILURE CENTER

Carlos Orrego, MD, FACC
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6717 N. 59TH Ave.
Glendale, AZ 85301

GENERAL INFORMATION/INFORMACION GENERAL

Patient Name/ Nombre:_____

☐ MALE/ HOMBRE ☐ FEMALE/ MUJER

Date of Birth/ Fecha de Nacimiento_____

Age/ Edad_____

Address/ Domicilio_____

City/ Cuidad_____ Zip Code/ Codico Postal_____

☎Home/ Casa_____ Cell/Celular_____

☐ Single/ Soltero ☐ Married/ Casado

Occupation/ Tipo de Trabajo_____

In case of an emergency, who should we call?/ En caso de una emergencia, a quien llamamos?

Name/ Nombre_____

Relation to Patient/ Relacion de Paciente_____

Phone Number/ Numero de Telefono_____

Texas Cardiology & Wellness Center, PLLC
DBA Cardiovascular & Heart Failure center

Office Financial Policy

Our goal is to provide you with quality, cost effective medical care, and maintain a good physician-patient relationship. Letting you know in advance about our office policy permits for a good communication and enables us to achieve our goal.

Please understand that the financial responsibility for medical services is between you and your health plan. While we will bill your insurance as a courtesy to you, we are not responsible for any limitations in coverage that may be included in your plan. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. According to your insurance plan, you are responsible for all co-payments, deductibles and coinsurances at the time of service.
2. If you have no insurance or if the services being provided are not covered by your insurance, you will be expected to provide payment in full at the time services are rendered.
3. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.
4. It is your responsibility to know and understand your benefit plan. It is your responsibility to know if an authorization or written referral is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. We require 24-hour notice for canceling any appointments. There is a **$25** charge for appointments canceled after 24-hour notice.
6. If you receive a payment from your insurance by mistake, please bring it along with any paperwork to our office.

I have read and understand my obligations and responsibilities.

Signature of Patient or Authorized Representative Date

Texas Cardiology & Wellness Center, PLLC
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Patient Authorizations

1. Consent to Treatment
I hereby consent to evaluation, testing and treatment as directed by my physician or his/her designee. _____ Initial

2. Assignment of Insurance Benefits/Patient Financial Responsibility
I hereby authorize direct payment of my insurance benefits to the Texas Cardiology & Wellness Center for services rendered to me by Texas Cardiology & Wellness Center providers.
I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered by my benefits. I understand and agree that I will be responsible for any balance due that Texas Cardiology & Wellness Center is not able to collect from my insurance carrier for whatever reason.

_____Initial

3. Insurance and Medicare/Medicaid Benefits
I request that payment from Medicare/Medicaid or any other insurance carrier be made on my behalf to Texas Cardiology & Wellness Center PLLC. I authorize the release of any of my records that these programs may request. I authorize any holder of medical information about me to be released to the Center for Medicare and Medicaid and its agents or insurance company and any information needed to determine these benefits payable for related services.

_____Initial

4. Lab/ Diagnostic Services
I understand that I may receive a separate bill if my medical care includes lab, diagnostic services. I also understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for any reason.

_____Initial

5. Authorization to release Non-Public Personal Information and receipt of Privacy (HIPAA) Policy
I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize Texas Cardiology & Wellness Center PLLC to release any of my medical or incidental non-public personal information that may be necessary for evaluation, treatment, consultation or the processing of insurance benefits.

I do not wish my information to be disclosed to any person ____ initial

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____Initial

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone:

_____

6. Authorization to Mail, Call or E-mail

I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize a representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the Texas Cardiology & Wellness Center in writing.

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for providing correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier.

_____

Signature of Patient or Authorized Representative Date
(electronic signature is applicable)
I agree with all previous Authorizations

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to Cardiovascular & Heart Failure Center (individual seeking the information). Dr. Carlos Orrego.

2. Effective Period

This authorization for release of information covers the period of healthcare from:

A. _____ to _____. **OR**

B. All past, present, and future periods.

3. Extent of Authorization

A. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). **OR**

B. I authorize the release of my complete health record with the exception of the of the following information:

_____Mental health records

_____ Communicable diseases (including HIV and AIDS)

_____ abuse treatment

_____Other (please specify):_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Signature of patient or personal representative

_____ Printed name of patient or personal representative and his or her relationship to patient

_____Date