Dr. Henock Zabher, M.D., FACC, FSCAI
2301 South FM 51, Ste. 400, Decatur, TX. 76234
3412 N Tarrant Pkwy., Suite 520, Ft. Worth, TX 76177
Phone: 940-626-2461 | Fax: 940-626-2462

Last Name: _____ First Name: _____ Middle:_____

Sex: M F Date of Birth: _____ Social Security Number: _____

Driver's License Number: _____ Marital Status: M S W D

Mailing Address:_____ City: _____

State: _____ Zip: _____ Sex: M F

Home Number: _____ Cell Number: _____ Work Number: _____

Leave Voice Message? Y N Leave Text Message? Y N

Leave Texts and Voicemails In: Morning Afternoon Evening

Email Address: _____

Race: Asian White Hispanic Indian African American Other Language: English Spanish

Occupation: _____ Employer's Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Are you a Veteran? Y N Emergency Contact Name: _____

Relationship: _____ Emergency Contact's Home Number: _____ _____

Emergency Contact's Work Number: _____ Emergency Contact's Cell Number: _____

Pharmacy Name: _____ Pharmacy City / Phone: _____

Insurance Company: _____ Policy Number: _____

Group Number: _____ Subscriber's Name: _____

Date of Birth: _____ / _____ / _____ Social Security Number: _____

Patient Name: **DOB:**

Referring Doctor: _____

Any other physician you've seen for the reason you are being seen for today:

_____

In your own words, why are you here to see us today?

_____

_____

Do you have any medical problems? (Circle those that apply): None

Hypertension	Diabetes (type I or type II)	Asthma
Hypotension	Heart Disease	CHF
Lung Cancer	Heart Attack	COPD
Abnormal Heart Rhythm	Atrial Fibrillation	Angina
Peripheral Vascular Disease	Syncope	Valve Replacement or Repair

Other: _____

Have you had a stroke? Yes No

If yes, did you or are you experiencing weakness? _____

If yes, where? _____

Please list any other problems that you are seeing a physician or take medication for:

_____

_____

_____

ANY surgeries or other procedures? (please list)

Procedure	Date	Where
Stent	Y N _____	_____
Left Heart Cath	Y N _____	_____
CABG	Y N _____	_____
Pacemaker	Y N _____	_____
Blood Transfusion	Y N _____	_____
Other _____	Y N _____	_____
Other _____	Y N _____	_____

Please name all your medications ***WITH dosages and how often it's taken,*** including herbal supplements and vitamins. (or attach list).

Medication Name	*Dosage*	*How Taken*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? Yes No If yes, please list:

_____

_____

_____

Have you been in the hospital in the last 6 months? (If so, for what? And what date?)

_____

_____

_____

Have you been to the ER in the last 6 months? (If so, for what? And what date?)

_____

_____

_____

Immunizations: (Please list the last time you had any immunizations)

Pneumovax: (Pneumonia shot) Yes No Date: _____

Flu shot: Yes No Date: _____

Social History

Do you currently work? Yes No

If yes, where? _____

In what industries have you worked?

_____

Do you smoke or have you ever smoked? Yes No

If yes, how old were you when you started? _____ Stopped? _____

How many packs per day on average (when you were at your worst)? _____

Do you smoke e-cigarettes? Yes No

Do you drink alcohol? Yes No Have you ever? Yes No

What do you drink? _____ How many drinks per week? _____

Do you currently or have you ever used recreational (illicit) drugs? Yes No

If yes, which ones and for how long?

_____

Family History

Father Alive or Deceased Cause of Death _____ Age _____

Mother Alive or Deceased Cause of Death _____ Age _____

Children? Yes No How Many? _____ Ages and Gender? _____

Do your children live at home? Yes No

Do you live with other people? Yes No

If other than spouse or children, please list.

_____

Do any illnesses run in your family? Please list.

_____

Do you know of any heart diseases that run in your family? Please list.

_____

Please list any and all surgeries that you have had done.

_____

Are you experiencing any of the following?

1. Constitutional:
   - ☐ Excessive Perspiration/ Sweats
   - ☐ Chills
   - ☐ Fatigue
   - ☐ Fever
   - ☐ Weakness
   - ☐ Weight Gain
   - ☐ Weight Loss

2. Ophthalmologic (eyes):
   - ☐ Loss of Vision

3. Cardiology:
   - ☐ Pain in Legs Walking
   - ☐ Syncope (Passing Out)
   - ☐ Chest Pain
   - ☐ Dizziness
   - ☐ Leg Edema
   - ☐ Heart Palpitations
   - ☐ Varicose Veins
   - ☐ Leg Pain (Claudication)

4. Hematologic/Lymphatic (Blood):
   - ☐ History of Blood Transfusion

5. Respiratory (Lungs):
   - ☐ Chest Tightness
   - ☐ Coughing Up Mucus
   - ☐ Chest Pain
   - ☐ Chest Congestion
   - ☐ Cough
   - ☐ Cough Up Blood
   - ☐ Wheezing
   - ☐ Shortness of Breath

6. Gastrointestinal (stomach and bowels):
   - ☐ Vomiting
   - ☐ Abdominal Pain
   - ☐ Blood in Stool
   - ☐ Bloating
   - ☐ Constipation
   - ☐ Belching
   - ☐ Diarrhea
   - ☐ Vomiting Blood
   - ☐ Heartburn
   - ☐ Nausea
   - ☐ Indigestion

7. Endocrine/Metabolic:
   - ☐ Diabetes
   - ☐ Elevated Cholesterol
   - ☐ Elevated Triglycerides

8. Sleep History:
   - ☐ Leg Cramps
   - ☐ Leg Jerks
   - ☐ Nocturnal Pain
   - ☐ Shift or Night Work
   - ☐ Snoring
   - ☐ Waking Up Tired
   - ☐ Poor Sleep Quality
   - ☐ Fall Asleep Driving
   - ☐ Daytime Fatigue
   - ☐ Daytime Sleepiness

Premier Cardiology Care

Thank you for choosing Premier Cardiology Care (PCC) as your healthcare provider. This office is committed to your health and successful treatment. Please understand that payment of your services is considered part of your treatment. We ask that you please read the following FINANCIAL POLICY and sign the forms prior to any treatment. **ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME THE SERRVICE IS RENDERED. IF OTHER ARRANGMENTS NEED TO BE MADE PLEASE SPEAK WITH THE RECEPTIONIST PRIOR TO YOUR VISIT. WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD.**

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

_____(**initials**) I hereby give authorization of insurance benefits to be made directly o PCC for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs to collection. I hereby authorize this healthcare provider to release information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

INSURANCE

_____ (**initials**) We do accept assignment on your insurance benefits. We must have your insurance information to do any insurance billing. In event that your insurance company does not pay, we reserve the right to transfer your balances to your responsibility. We will be happy to assist you by providing you with claim forms and an explanation of benefits from your primary insurance after your balance with us is satisfied. Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan. All copays and deductibles are due at the time of treatment unless prior billing arrangements have been made. If your insurance requires a referral, we request that you bring it with you at the time of your visit. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans. This assignment will remain in effect until revoked by me in writing. A copy of the Assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges. I hereby authorize Premier Cardiology Care to release all information necessary to secure payment.

MEDICARE GUIDELINES

_____(**initials**) I authorized any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information need for this or related to Medicare claims. I permit a copy of this request for payment of medical insurance benefits either to myself or the responsible party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

USUAL AND CUSTOMARY RATES

_____ (**initials**) Premier Cardiology Care is committed to providing the best treatment for our patients and we charge what is usually and customary for our area. You are responsible for the minor. Payments for services provided to minors is due at time of service.

FORMS COMPLETETION

_____ (**initials**) There will be a $10.00- $25.00 charge for items for which the physician and/or staff are required to complete including but not limiting the following items:

a. Letter of Medical Necessity
b. Family Medical Leave Forms
c. Disability Forms
d. Application for handicapped parking permits and/or license
e. Prior authorization of medications through an insurance company

Thank you for understanding out **FINANCIAL POLICY.** Please let us know if you have any questions or concerns. I have read the **FINANCIAL POLICY.** I understand and agree to this policy.

Patient Signature: _____ Date: _____

Premier Cardiology Care

Patient Rights

We make no distinction in the availability of services; the admission, transfer or discharge of patients; or in the care we provide based on age, gender, disability, race, color, religion, or national origin. We recognize and respect the diverse backgrounds and cultures of our patients and make every effort to equip our caregivers with the knowledge and resources to respect each patient's cultural heritage and needs.

We are mindful that the populations we serve are becoming even more divers. Accordingly, we are structuring more formal programs to ensure that Premier Cardiology Care (PCC) colleagues are equipped to meet these articulated commitments for multi-cultural competency in patient care. PCC respects the patient's right to and need for effective communication.

Each patient is provided with the opportunity to view or receive a copy of **PCC Patient Rights** and a **Notice of Privacy Practices.** These statements include the rights of the patient to make the following decisions:

Make decisions regarding medical care

The right to refuse or accept treatment

The right to informed decision making

The right to know and access the information in your medical records

Such statements, like those mentioned above, conform to all applicable state, and Federal laws including, but not limited to the **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HERINAFTER REFFERED TO AS HIPAA).**

We seek to involve patients in all aspects of their care, including giving consent for treatment and making healthcare decisions. Some of which may include, managing pain effectively, foregoing or withdrawing treatment, and as appropriate, care at the end of life. PCC addresses the wishes of the patient relation to end of life decisions. As applicable, each patient or patient representative, is provided with a clear explanation of care including, but not limited to: diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, estimates of treatment cost, organ donation and procurement, and an explanation of the risks, benefits, and alternatives associated with available treatment options.

Patients have the right to request transfers to other facilities. In such cases, the patient is given an explanation of benefits, risks, and alternatives of the transfer. Patients are provided information regarding their right to designation of surrogate healthcare decision-makers. Patient advance directives or resuscitate measures are honored within the limits of the law and our organization's patient's rights. Each patient and his or her representatives are accorded appropriate confidentiality, privacy security, advocacy and protective services, opportunity for resolution of complaints, and pastoral care, or spiritual care.

Patients have the right to an environment that preserves dignity and contributes to positive self-image. Patients are treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights, and involvement in their own care.

PCC facilities maintain procedures to support patient rights in collaborative manner which involves the facility leaders and others. These structures are based on policies and procedures, which make up the framework addressing both patient care and organizational ethics issues. These structures include, informing each patient or, when appropriate, the patient's representative in advance of furnishing or discontinuing care.

Patients receive information about the person(s) responsible for their care, treatment and services. Patient, and when appropriate, their families are informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes. Patients are involved as clinically appropriate in resolving dilemmas about care decisions.

Facilities maintain procedures for prompt resolution of patient grievances which include informing patients of their rights regarding the grievance process. PCC addresses the resolution of complaints from patients and their families. Patients have the right to refuse care, treatment, and services in accordance with the law and regulations. PCC facilities maintain an ongoing and proactive patient safety. All statistics involving patient safety

and healthcare errors are reported. PCC colleagues receive training about patient rights in order to clearly understand their role in supporting their patients. We strive to promote total wellness through targeted health education and illness-prevention programs that improve the quality of life of our patients and our communities.

Acknowledgment of Patient Rights

I have read the NOTICE OF PATIENT RIGHTS and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Rights Notice.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Acknowledgment of Patient Responsibilities

I have read the NOTIVE OF PATIENT RESPONSIBILITIES and have had any questions answered by this office. I understand that by signing this for I acknowledge that have read the Patient Responsibilities Notice.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

_____ _____

Patient's Name (printed) **Date**

_____

Patient's Signature (or guardian, if a minor)

ACKNOWLEDGEMENT OF PATIENT RESPONSIBILITIES

_____ (**initials**) I have read the **NOTICE OF PATIENT RESPONISBILITIES** and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Responsibilities Notice posted in all PCC locations. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

CONSENT FOR TREATMENT FORM

_____ (**initials**) I understand that I have presented myself to PCC for evaluation and/or treatment for my condition. I authorize and direct PCC to perform quality care upon me and understand that all options will be discussed prior to the administration of such treatment. I acknowledge that the practice of medicine is not exact science and that no guarantees have been made to me as an outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Premier Cardiology Care

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

FACSIMILE AUTHORIZATION FORM

_____ (**initials**) I the undersigned, authorize Premier Cardiology Care (PCC) to send/receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed. I may revoke this authorization by giving PCC five (5) days written notice. This revocation may be by facsimile transmission; however, a written copy of the revocation must be mailed to PCC as well.

_____ (**initials**) I acknowledge that PCC has provided me with the opportunity to view and read a written copy of their Notice of Privacy Practices.

_____ (**initials**) I acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS & CONSENT OF DISCLOSURE OF INFORMATION

_____(**initials**) I acknowledge that Premier Cardiology Care will disclose my Protected Health Information (PHI) to a family member, other relatives, close friends or any other person I identify that directly relates to that person's involvement in my care.

Person(s) _____ Phone Number _____ Relationship_____

Person(s)_____Phone Number _____Relationship_____

Or

_____ (**initials**) I **OBJECT** to the disclosure of my **Protected health Information** to a family member, other relatives, close friends or any other person.

_____ (**initials**) **SHARING OF INFORMATION FOR PURPOSE OF PAYMENT:** I acknowledge that PCC will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to) benefit determination and utilization review as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data ware houses, and billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including, but not limited to) the credentialing for ongoing operations for this office and any relevant processes, the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

COMMUNICATION AUTHORIZATION

_____ (**initials**) I acknowledge that Premier Cardiology Care may communicate with me via US mail, home phone, through the patient portal, on a cell phone and through text message.

Patient Signature: _____

Personal Representative Signature: _____Relationship to Patient: _____

Premier Cardiology Care

Authorization for use or Disclosure of Protected Health Information

Patient's Name: _____

Social Security Number: _____DOB: _____

Day time Phone Number: _____ Evening Phone Number: _____

Address:_____

City: _____ State: _____ Zip Code: _____

I herby authorize _____ to use or disclose my protected health information as indicated below to

Premier Cardiology Care 2301 South FM 51 suite 400 Decatur, Texas 76234 Phone #: 940-626-2461
Fax#: 940-626-2462

Information to be released:

From & To Dates: _____

__ Copy of complete medical records
__Information related to HIV testing results
__History and Physical/ Consultation reports
__Laboratory, X-rays, PFT, Echo, Angio, OP reports
__ Other _____

Purpose of Disclosure:

__Changing Physician __Second Opinion
__Continuing Care __Legal
__At my (patient) request __Insurance
__Worker's Compensation __School
Other:_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

__ Substance Abuse (including alcohol/drug use)
__Mental Health
__Psychotherapy Notes
__HIV related information (including AIDS related testing)

Signature of Patient or Legal Guardian_____
Date_____

1. I understand that this authorization will expire two years from my last date of service. A photocopy of this form will be considered as valid as the original.
2. I understand that information used or discolored pursuant to this authorization may be subject to redisclosure by the by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information.
3. My healthcare and payment or my healthcare will not be affected if I do not sign this form.
4. I understand that I will get a copy of this form after I sign it. Signing below I acknowledge that I have read and understand this Authorization.

Signature_____ **Relationship**_____ **Date**_____

Premier Cardiology Care

1) ***Appointments Policy: Scheduled/Cancellation/ No Show***

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. There are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged, FIFTY dollars ($50.00) fee; this will not be covered by your insurance company. If a patient is 15 minutes past their scheduled time, we will have to reschedule their appointment. Both situations are considered a No Show.** After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

2) ***Patient Refill Request Policy***

At Premier Cardiology Care our mission is to serve our patient with the best quality care available. To help us reach that goal we ask that you keep the following this in mind when it is time to get your medications filled for the first time or when you request refills.

A) If your prescription requires our office visit to refill, please call us to schedule an appointment two weeks before your prescription runs out.
B) Once an order has been put in at the office please allow at least 24-48 hours for the prescription to be ready at your pharmacy.
C) If your refill request has been submitted for 24-48 hours and you have not heard back from your pharmacy that your prescription is ready for pick up, please call the office to verify that the fax or electronic request made it through to your pharmacy.
D) Please allow 3-4 business days for some schedule 2 medications (Controlled) to arrive at your pharmacy. Some of these controlled medications are only available to be picked up at the clinic. If you are not sure just ask your provider.

3) ***Account Balances***

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their accounts and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ _____

Printed Name **Patient Signature** **Date**