CARDIAC WELLNESS CLINIC

Dr. John Yu, MD FRCP (C), FACC 1930
Country Place Parkway Suite 106
Pearland,Texas 77584

281-506-7840 (P) 832-672-7485 (F)

Patient Information

Name: _____ Preferred first name: _____

DOB: _____ ❑ Female ❑ Male SSN: _____

Primary phone: _____ Type: ❑ Home ❑ Cell ❑ Work Marital status: _____

Primary patient notification preference: ❑ Primary phone ❑ Secondary phone ❑ Mail

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

Primary language: _____ ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Primary address: _____

City: _____ State: _____ Zip: _____

Secondary phone: _____ Type: ❑ Home ❑ Cell ❑ Work

Personal email*: _____ Preferred method of notification: ❑ Phone ❑ Email

**Personal email is required for access to the patient portal*

Additional Patient Information

Primary care physician: _____

Person financially responsible: _____ Relationship: _____

Referring physician (if different from primary care): _____

Employer: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Emergency contact: _____ Emergency contact: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary ID: _____ Secondary ID: _____

Policy Holder & DOB _____

Pharmacy : _____ Pharmacy Location: _____

Pharmacy phone number: _____

Extended Information

Payment Policy

Thank you for choosing us as your Cardiac Provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1.Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with,but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2.Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3.Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4.Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5.Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6.Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7.Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8.Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. We are available and understand that sometimes financial hardships due occur. We will do our best to set up individual payment plans in this instance.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Authorization

I authorize **CARDIAC WELLNESS CLINIC** to disclose my Protected Health Information to my spouse and/or other

person(s) Print Name: _____ Date of birth: _____

Patient Signature: _____

(Or parent if patient is a minor)

Name(s) and Relationship(s):_____

_____

_____

CARDIAC WELLNESS CLINIC

Please check all that apply below:

Patient Name_____

Allergy

- ❑ sinus congestion
- ❑ tinnitus

Respiratory

- ❑ wheezing
- ❑ cough

Cardiology

- ❑ chest pain
- ❑ palpitations
- ❑ leg swelling (Edema)
- ❑ dizziness
- ❑ shortness of breath
- ❑ varicose veins
- ❑ claudication

Constitutional

- ❑ fever
- ❑ chills

Dermatology

- ❑ rash
- ❑ hives

- ❑ **Endocrinology**
- ❑ fatigue
- ❑ cold intolerance
- ❑ heat intolerance

ENT

- ❑ hearing loss
- ❑ sore throat
- ❑ ringing in ears

Gastroenterology

- ❑ nausea
- ❑ vomiting
- ❑ abdominal pain

Hematology

- ❑ swollen gland
- ❑ easy bruising

Musculoskeletal

- ❑ joint swelling
- ❑ joint pain

Neurology

- ❑ memory loss
- ❑ weakness of extremity
- ❑ disturbance of skin sensation

Ophthalmology

- ❑ Eye irritation
- ❑ loss of vision

Psychology

- ❑ depression
- ❑ anxiety

Urology

- ❑ blood in urine
- ❑ dysuria

Drug Allergies

- ❑ **PENICILLIN**
- ❑ **ASPIRIN**
- ❑ **SULFA DRUGS**
- ❑ **OTHER PLEASE SPECIFY BELOW:**

_____

_____

_____

_____

_____

Current Medications and dosages

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

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Patient Name_____ Date of Birth_____

The above-named person is a patient of: Dr. John Yu, MD

The above-named patient hereby authorizes representatives from Cardiac Wellness Clinic to:

____Request health information from

____Send Health information to

____Discuss health information with

____All information regarding care received by patient

Name of person/facility: _____ Date:_____

Phone: _____ Fax: _____

Printed name of Patient of Authorized Representative: _____

_____ _____
Signature of Patient Date

If not signed by the patient, indicate relationship of authorizing person to patient: _____