Younis Cardiology Associates
Registration Form

Patient Name:_____ Date of Birth:_____

Social Security Number:_____ Marital Status: ☐S ☐M ☐D ☐W Sex: ☐M ☐F

Primary Care Provider: Name_____ Tel._____

Referring Provider: Name_____ Tel._____

Home Phone:_____ Work Phone:_____Cell Phone:_____

Address:_____City:_____ State:_____ Zip:_____

E-mail Address:_____ Employer:_____

Emergency Contact:Name_____Tel._____

Pharmacy:Name_____Address_____Tel._____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

*** Please provide us with your current insurance cards. ***

Circle one: **1.** American Indian/Alaskan Native **2.** Asian **3.** Native Hawaiian **4.** Black/African American

5. White **6.** Hispanic **7.** Other Pacific Islander **8.** Other Race **9.** Decline to Answer

I AUTHORIZE INFORMATION ABOUT MY HEALTH/RESULTS BE CONVEYED VIA:

MY PRIMARY PHONE #: (circle one) Cell Home Work Other
SECOND CHOICE #:(circle one) Cell Home Work Other

WE WILL LEAVE DETAILED VOICE MESSAGES REGARDING YOUR HEALTH/RESULTS IF WE'RE UNABLE TO CONTACT YOU ON THE NUMBER(S) LISTED ABOVE. TO DECLINE VOICE MESSAGES PLEASE CHECK THE BOX . ☐

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes relatives, friends, and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature:_____ **Date:**_____

Younis Cardiology Associates

Patient Acknowledgement of Receipt of Privacy Practices and Office Policies Form

Thank you for choosing Younis Cardiology Associates. We realize you have a choice in selecting cardiovascular care and are honored that you have chosen us. Our entire staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with some information regarding our office policies. Please let us know if you have any questions.

Office Hours: Although appointment times may vary, in general our office staff is available by telephone from 8:30 a.m. to 5:00 p.m. Monday - Friday. Outside of scheduled office hours, your calls will be answered by our answering service. In the event your call is an emergency, please call 911 for immediate assistance. If you need to make an appointment, please call during business hours.

Appointments: YCA is committed to providing continuous coverage and quality care to our patients. When calling for an appointment, please let us know which physician you are requesting to see, and provide any updated personal or insurance information. **Kindly notify us of any cancellation within 24 hours of your scheduled appointment so that we may use that time to see other patients.**

Nuclear Stress Tests: Performing a nuclear stress test requires advance preparation including purchase of the necessary radioactive tracer for each patient. If you are unable to make your scheduled nuclear stress test, please notify us at least 24 hours in advance. **Failure to notify us may result in a $300.00 fee to cover the materials purchased in preparation for your test.**

Medical Records: Requests for your medical records must be received in writing. Please contact our office for a records release form. Also, note that a fee of $6.50 will apply to any patient requesting records. As for insurance companies a $25.00 fee will be assessed for the first 20 pages and $0.15 for each additional page.

Insurance: When providing your insurance information you hereby give authorization for payment of insurance benefits to be made directly to Younis Cardiology Associates (YCA). **You are responsible to pay, at the time of service, any deductible, co-pay, co-insurance, and any non-covered services**, as stated in your insurance contract. If we are unable to verify your insurance coverage before your appointment, you may either reschedule your visit or be held responsible for all fees accrued on that particular date of service. If your insurance company does not pay your claim within 60 days, the charges will be your responsibility.

Prescription Refills: If you are in need of a prescription refill, please have your pharmacy contact us at least one week before your prescription runs out. Refills will be addressed within 24 hours of request. Please be advised that refill requests will be honored in very limited capacity for those patients who have not been seen in more than one year.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices and Office Policies for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.** You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Please *print* your name	Please *sign* your name	Date
Patient's Legal Representative	Description of Authority	Date

Younis Cardiology Associates

Authorization to release healthcare information to us from outside facilities

Patient's Name: _____ Date of Birth: _____

I request and authorize _____

to release healthcare information of the patient named above to:

Younis Cardiology Associates
6624 Fannin St, Suite 2420
Houston, TX 77030
Phone 713-790-0400 **Fax 713-799-2121**

This request and authorization applies to:

□ All healthcare information

□ Healthcare information relating to the following treatment, condition, or dates:

I authorize the release of STD* results, HIV and AIDS testing, whether negative or positive, to the person (s) listed above. I understand that the person (s) listed above will be notified that I must give specific written permission before disclosure of these results to anyone.

□ Yes □ No

I authorize the release of any records regarding alcohol, or mental health treatment to the person (s) listed above.

□ Yes□ No

Patient's Signature: _____ Date Signed: _____

***Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, nonspecific urethritis, syphilis, DVRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea □ Yes □ No