REGISTRATION FORM

DATE: _____ REFERRED BY: _____

PATIENT NAME: _____ MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W

DATE OF BIRTH: _____ AGE: _____ SEX: ☐ M ☐ F

SOCIAL SECURITY NUMBER: _____ PRIMARY CARE MD: _____

HOME PHONE: _____WORK PHONE: _____ CELL PHONE: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

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

EMAIL ADDRESS: _____ OCCUPATION: _____

PHARMACY NAME: _____ PHARMACY ADDRESS: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INSURANCE COMPANY NAME: _____

INSURANCE ID#_____GROUP # _____

NAME OF INSURED: _____ INSURED'S EMPLOYER: _____

INSURED DOB: _____ RELATION TO INSURED: _____

SECONDARY INSURANCE CO: _____

INSURANCE ID#_____ GROUP # _____

NAME OF INSURED: _____ INSURED'S EMPLOYER: _____

INSURED DOB: _____ RELATION TO INSURED: _____

I AUTHORIZE INFORMATION ABOUT MY HEALTH/RESULTS TO BE CONVERYED VIA:

MY PRIMARY PHONE # (CIRCLE ONE) CELL HOME WORK **SECOND CHOICE #:** (CIRCLE ONE) CELL HOME WORK

WE WILL LEAVE DETAILED VOICE MESSAGES REGARDING YOUR HEALTH/RESULTS IF WE ARE NOT ABLE TO CONTACT YOU ON THE NUMBER(S) LISTED ABOVE. TO DECLINE VOICE MESSAGES PLEASE CHECK THIS BOX ☐

PLEASE LIST ANY OTHER PEOPLE WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

SIGNATURE: _____ **DATE:** _____

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 8:30 a.m. to 5:00 p.m. Monday through 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 your telephone number, physician you are requesting to see, and 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 form of records release. Also, note that a medical records fee may be assessed.

Insurance: YCA will be happy to file your insurance claims as a courtesy. **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. Alternatively, you may call our office and leave a message on our refill line. Be sure to include the name of the medication, the pharmacy number, and a number where you can be reached. 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 physicians or facilities in the future.** You may refuse to sign this acknowledgement and 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

HIPAA Privacy Authorization Form

Patient Name: _____ Date of Birth: _____

For the purpose of continuity of care, I request and authorize

_____ (another healthcare provider or hospital)

to use and disclose the protected healthcare information of the patient named above to:

Younis Cardiology Associates, PLLC

6560 Fannin St., Suite 1750

Houston, TX 77030

Phone 713-790-0400. Fax 713-799-2121

This request and authorization applies to:

□ All healthcare information

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

_____ _____

Patient's Signature Date Signed