North Texas Heart Care

Vidyasagar Chodimella, MD., PA., FACC

PATIENT ACCOUNT #: _____

First Name: _____ M.I. ____ Last Name: _____ Date: _____

SSN: _____ DOB: _____ Age: _____ Race: _____ Sex: M/F

REFERRED BY: _____ REASON FOR VISIT: _____

(cv problem list/cc/hpi) E/MCode: _____ (Physician Use Only)

CARDIAC RISK FACTORS: Please Check All Appropriate Conditions

- ❑ Smoker
  - Current/Former (circle)
  - Packs/Years _____
- ❑ Elevated Cholesterol/Fats
  - Chol _____ LDL _____
  - HDL _____ TG _____
- ❑ High/Elevated Blood Pressure
- ❑ Leg Pain with Exercise (P.V.D.)
- ❑ Chronic Lung Disease
- ❑ Family History Heart Attack
  - Mother/Father/Sibling (circle)
  - Age of Onset _____
- ❑ Post Menopausal
- ❑ Diabetes
- ❑ Overweight
- ❑ Sedentary Lifestyle
- ❑ Alcohol Abuse
- ❑ Renal Failure

PAST MEDICAL HISTORY: Please List Past Hospitalizations/Surgeries Or Major Illnesses And Dates

_____

_____

_____

Marital Status: ❑ M ❑ S ❑ D ❑ W Spouse's Name: _____ # of Children: _____

Hobbies: _____ Occupation: _____ Spouse's Occupation: _____

CURRENT MEDICATIONS DOSAGE FREQUENCY

1 _____

2 _____

3 _____

4 _____

5 _____

ALLERGIES TO MEDICATIONS: Please Include The Reaction From The Medicine

_____

Allergic to Dye: ❑ Yes ❑ No

REVIEW OF SYSTEMS: Please Check All That Apply

CARDIOVASCULAR
- ❑ Palpitations
- ❑ Leg Pain on Exertion/Exercise
- ❑ Chest Discomfort
- ❑ Heart Murmur
- ❑ Dizziness
- ❑ Passing Out
- ❑ Swelling
- ❑ Recent Weight Change

PULMONARY
- ❑ Recent Cough/Wheezing
- ❑ Chronic Cough/Wheezing
- ❑ Blood in Phlegm
- ❑ Shortness of Breath

GASTROINTESTINAL
- ❑ Abdominal Pain
- ❑ Rectal Bleeding
- ❑ Indigestion
- ❑ Ulcer History
- ❑ Hiatal Hernia
- ❑ Gallstones
- ❑ Hepatitis
- ❑ Constipation
- ❑ Diarrhea
- ❑ Liver Problems

RENAL
- ❑ Prostrate Problems
- ❑ Kidney Stones
- ❑ Urinary Tract Infections
- ❑ Blood in Urine
- ❑ Chronic Renal Failure

NEUROLOGIC
- ❑ Stroke
- ❑ Passing Out
- ❑ Blind Spots
- ❑ New Numbness
- ❑ New Weakness
- ❑ Slurred Speech
- ❑ Chronic Headache

OTHER HISTORY
- ❑ Arthritis
- ❑ Rheumatic Fever History
- ❑ Diabetes
- ❑ Cancer
- ❑ Thyroid Problems
- ❑ Bleeding Problems
- ❑ Diet Pill Use History
- ❑ Endocarditis
- ❑ AIDS
- ❑ Sexually Transmitted Disease(s)
- ❑ Other: _____

North Texas Heart Care

Vidyasagar Chodimella, MD., PA., FACC

Authorization and Assignment

Patient Information

PLEASE PRINT

Date		Referring Physician	
Patient Name			
Address		Home Phone #	
City	State	Zip	E-mail Address
Sex	Marital Status	DOB	Race
SS #		Occupation	
Employer		Work Phone	
Spouse's Name		Spouse's Work #	

Advanced Directive

Please check all that apply. Yes, I have a:

_____Living Will _____Durable Power of Attorney _____Out of Hospital DNR _____Mental Health Advance Directive

_____No, I do not have an Advnace Directive but would like more information

EMERGENCY CONTACT

Name _____

Phone Number _____ Relationship _____

Authorization and Assignment

I hereby grant permission for Vidyasagar Chodimella, MD, PA, FACC, FCCP to disclose medical information to other treating physicians regarding my care. In addition, I authorize the release of such records for the purpose of obtaining reimbursement in my insurance company(ies).

All medical/surgical benefits are assigned to the Vidyasagar Chodimella, MD, PA, FACC, FCCP for billed services. I understand that I am financially responsible for charges related to my medical and/or surgical services.

I hereby grant Vidyasagar Chodimella, MD, PA, FACC, FCCP physicians and staff to diagnose and treat any condition that I present with whether presenting in the office, hospital, or through telephone contact.

I understand that insurance is filed as a courtesy and that remaining balances are my responsibility. I hereby authorize Vidyasagar Chodimella, MD, PA, FACC, FCCP a copy of my credit report should such balance beme delinquent or should I request to set up a payment plan. Patient balances not paid in full within 30 days are considered delinquent. Insurance balances are not paid in full within 60 days are considered delinquent.

Patient (or Legal Guardian)	Date

Vidyasagar Chodimella, MD, FACC, P.A.

PF-1000 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address shown below. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
Vidyasagar Chodimella, MD, FACC, P.A.
Vidyasagar Chodimella, MD
4325 N. Josey Lane, Suite 204
Carrollton, TX 75010
972-395-7400

Effective Date

This Notice is effective on or after April 14, 2003.

Vidyasagar Chodimella, MD, FACC, P.A.

PF-2000 **Acknowledgement of Receipt of Notice of Privacy Practices**

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

Vidyasagar Chodimella, MD, FACC, P.A.

PF-3000 Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

_____ all Information In my files, or

_____

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

___ education, discussion of treatment plan, medical decision making, or

_____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Vidyasagar Chodimella, MD, FACC, P.A., and

_____

Name of person/organization

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

_____

Name of person/organization

_____

Name of person/organization

Expiration Date of Authorization

This authorization is effective unless and until revoked by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Individual

- ☐ You may inspect or copy information used or disclosed under this authorization.
- ☐ You may refuse to sign this authorization.

Effect of Refusing Authorization

If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

_____

Treatment conditioned on authorization

Signature

_____

Name of Patient (Print or Type)

_____

Signature of Patient Date

_____

Signature of Patient Representative

Relationship of Patient Representative to Patient:_____