INTERNATIONAL ROBOTIC SURGERY CENTER FOR THE HEART AND CHEST
HOUSTON VEIN INSTITUTE

PATIENTS EMAIL ADDRESS				
Patient Name (First, Middle, Last)	Date of Birth Age		Sex (M or F)	SS#
Address	City, State, Zip		Marital Status	
Home Phone #	Cell Phone #		Pharmacy Phone #	
I prefer to receive my phone calls at this number	Race	Ethnicity	Preferred Language	
Employer Name	Occupation		Work Phone #	
Emergency Contact Person	Relationship to Patient		Emergency Phone #	
Spouse Name (First, Middle, Last)	Spouse Cell Phone #		Spouse Other #	
Referring Physician Name	Phone #		Fax #	
Primary Care Physician Name	Phone #		Fax #	

RESPONSIBLE PARTY (if other than Patient)

Name (First, Middle, Last)	Date of Birth	Sex (M or F)	SS#
Address	City, State, Zip		Relationship to Patient
Home Phone #	Cell Phone #	Work Phone #	Other # (if any)

PRIMARY INSURANCE

Insurance Company Name	Policy ID#		Group ID#
Claims Address	City, State, Zip		Phone #
Policy Holder Name	Phone #	Sex (M or F)	Date of Birth
Policy Holder Address (if different than patient)	City, State, Zip		SS#
Relationship to Patient		Alternate Phone #'s	

SECONDARY INSURANCE

Insurance Company Name	Policy ID#		Group ID#
Claims Address	City, State, Zip		Phone #
Policy Holder Name	Phone #	Sex (M or F)	Date of Birth
Policy Holder Address (if different than patient)	City, State, Zip		SS#
Relationship to Patient		Alternate Phone #'s	

I hereby state that the above information is true and correct to the best of my knowledge.

Signature of Patient/Responsible Party _____ Printed Name _____ Date _____

INTERNATIONAL ROBOTIC SURGERY CENTER FOR THE HEART AND CHEST
HOUSTON VEIN INSTITUTE
CONFIDENTIAL HEALTH HISTORY

Patient Name:_____ **Date:**_____

Birthdate: _____ **Sex: Male Female** **Date of Last Physical:**_____

Cardiologist:_____ **Referring Doctor:**_____
(If Different)

Briefly explain your reason for seeing the Doctor today:_____

_____

List any allergies you have (including medication allergies):_____

_____

MEDICATIONS: List all medications you are currently taking and the dosage (or attach a list):

_____

_____

_____

MEDICAL HISTORY - Check the medical conditions you have or have had in the past year.

___Aids
___Alcoholism
___Anemia
___Arthritis
___Asthma
___Bleeding Dis.
___Breast Lump
___Bronchitis
___Cancer
___Cataracts
___Chemical Dependency
___Diabetes
___Emphysema
___Epilepsy
___Glaucoma
___Goiter
___Gout
___Heart Disease
___Hepatitis
___Hernia
___Herpes
___High Cholesterol
___HIV Positive
___Kidney Disease
___Liver Disease
___Migraine Headaches
___Multiple Sclerosis
___Pacemaker
___Pneumonia
___Polio
___Prostrate Problem
___Psychiatric Care
___Rheumatic Fever
___Scarlet Fever
___Stroke
___Thyroid Problems
___Tuberculosis
___Ulcers

SURGERIES:

Year	**Hospital**	**Reason for Hospitalization**

SOCIAL HISTORY: Check which substances you use and **indicate usage per week.**

___Tobacco # Years _____ # Packs per day_____ _____Drugs _____Alcohol #Drinks per Day_____

OCCUPATION:_____

FAMILY HISTORY: Fill in health information about your family.

	State of Health	**Age at Death**	**Cause of Death**
Father			
Mother			
Brothers/Sisters			

Miguel A. Gomez, MD, PA
18400 Katy Frwy, Suite 480
Houston, TX 77094

ACKNOWLEDGEMENT OF HIPAA FORM

I acknowledge I have read the HIPAA Notice of Miguel A. Gomez, MD, PA and below are listed family members and/or friends with whom it is permissible to share my PHI (Protected Healthcare Information). This authorization will stay in affect unless it is changed by me.

NAME OF PERSON(S) WHO MAY RECEIVE MY MEDICAL INFORMATION

NAME RELATIONSHIP PHONE NUMBER

I grant my permission to be contacted by any of the following means of communication (check all that apply):

_____ Home Telephone _____ Cell Phone _____ Email _____ Voicemail

SIGNATURE

PRINTED NAME OF PATIENT

DATE

Miguel A. Gomez, MD, PA
18400 Katy Frwy, Suite 480
Houston, TX 77094

PATIENT FINANCIAL POLICY

Thank you for choosing our office for your medical care. Our professional relationship will be enhanced by your clear understanding of our office policies. In order to better serve you, we kindly ask you to carefully read and indicate acceptance of these policies on each paragraph and your signature at the bottom. To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

_____PAYMENT FOR SERVICE: Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. All applicable fees such as deductible, co-insurance and co-pays must be paid at the time of your visit. Our office accepts cash, checks, debit and MasterCard, Visa or Discover. Payment returned to our office for insufficient funds, closure of account and/or credit card rejection will result in an assessment for $35 applied to your account.

_____INSURANCE VERIFICATION: As the policy holder, it is your responsibility to verify with your insurance carrier that Miguel A. Gomez, MD, PA is a participating provider with your plan. Our office makes every attempt to obtain current benefit information from your insurance carrier; however, it is your responsibility to understand your benefits. Please notify our office immediately of any changes to your medical insurance policy so that we may take the necessary steps to assist you in obtaining your maximum level of benefits.

_____CANCELLATIONS: If you must cancel or reschedule your appointment, please notify our office at least 24 hours in advance. You may call after hours and leave a message with the answering service. Cancellations or no shows within 24 hours of the scheduled appointment time will result in a $50 cancellation fee. Your insurance will not cover this charge.

_____

Printed name of patient

_____

Signature of Patient or Responsible Party if a minor

_____

Date

Miguel A. Gomez, MD, PA
18400 Katy Frwy, Suite 480
Houston, TX 77094

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Miguel A. Gomez, MD, PA as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Miguel A. Gomez, MD, PA, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Miguel A. Gomez, MD, PA, to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Miguel A. Gomez, MD, PA any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Miguel A. Gomez, MD, PA or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Miguel A. Gomez, MD, PA any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort-feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Miguel A. Gomez, MD, PA (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Miguel A. Gomez, MD, PA all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by Miguel A. Gomez, MD, PA, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Miguel A. Gomez, MD, PA) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Miguel A. Gomez, MD, PA as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

Date:_____

Miguel A. Gomez, MD, PA
Notices of Privacy and Protection of Health Information

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Miguel A. Gomez, MD, PA
Attn: Privacy Officer
Mailing Address: 18400 Katy Frwy, Suite 480
Houston, TX 77094
Phone (832)260-0500 Fax (832)260-0488

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

For Treatment. We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

For Payment. We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

For Health Care Operations. We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Research. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect, or Domestic Violence. We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

Law Enforcement. We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

Military Activity and National Security. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

Coroners, Medical Examiners, and Funeral Directors. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that

directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials please contact the Privacy Officer.

Your Written Authorization is required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; *and*
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV Information, Alcohol and Substance Abuse Information, Mental Health Information and Genetic Information.

This information will only be released with a special Medical Record Release form giving authorization for HIV, Alcohol and/or Substance Abuse, Mental Health, or Genetic Information to be released.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

Right to Inspect and Copy. You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to a Summary or Explanation. We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Request Amendments. If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail. The contact information is listed on Page 1 of this Notice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.