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

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 #	
PATIENTS EMAIL ADDRESS (required)		Preferred Language	
Employer Name	Patient's Occupation	Work Phone #	
Spouse or Emergency Contact Person	Relationship to Patient	Emergency Phone #	
Referring Physician Name	Phone #	Fax #	
Primary Care Physician Name	Phone #	Fax #	

RESPONSIBLE PARTY (if other than Patient)

Name (First, Middle, Last)	Date of Birth	SS#	
Address	City, State, Zip	Relationship to Patient	
Home Phone #	Cell Phone #	Work Phone #	

PRIMARY INSURANCE

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

SECONDARY INSURANCE

Insurance Company Name	Policy ID#	Group ID#	
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**

Height:_____ **Weight:** _____

Occupation: _____

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):

_____

_____

_____

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_____

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 48 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 $75 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:_____

International Robotic Surgery Center for the Heart and Chest
Houston Vein Institute

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Cardiovascular & Thoracic Surgery
18400 Katy Freeway, Suite 480
Houston, TX 77094
(832) 260-0500

Fax: (832) 260-0488

AUTHORIZATION FOR RELEASE OF RECORDS

TO: _____

FAX NO._____OFFICE NO._____

Please release recent medical records, as well as other pertinent information regarding your treatment of me.

PATIENT NAME:_____DATE OF BIRTH_____
(Please print legibly)

_____ _____
Patient Signature Date