Central Texas Heart Center PLLC

New Patient
Demographic Information

First name | Middle Name | Last Name

DOB: | M / F Gender | SSN

Race/Ethnicity: | Language (please specify): | *In compliance with Federal Regulations, we are required to collect this information.

Driver's License #: | State: | Exp. Date:

Mailing Address:

City: | State: | Zip Code:

Home Phone #: | Cell Phone #: | Alternative Phone #:

Email: | Employer/Phone#:

Spouse or Other Contact Name: | Phone #:

Primary Insurance | Subscriber #: | Group#

Subscriber Name | DOB | Insurance Phone #

Secondary Insurance | Subscriber #: | Group#

Subscriber Name: | DOB | Insurance Phone #

Primary Care Physician Name: | Phone #:

Have you ever seen a Cardiologist?

Cardiologist's Name/Phone #: | Reason?

*** I agree to consent for detailed messages to be left at any and all of the contact phone numbers and/or emails listed above.**

Patient/Guardian Signature

Central Texas Heart Center PLLC

NAME: _____ DOB: _____

Consent for Treatment:
I consent and authorize the providers of Central Texas Heart Center (CTHC) and associates to treat my condition as they deem necessary, including any procedures and scans. I understand that there are no warranties/guarantees in regards to the results of the healthcare provided to me. I am aware that I will be responsible for any charges that my insurance does not cover. I agree that it is my responsibility to know and understand my insurance benefits and coverage thereof and that any quote given to me by CTHC is not a guarantee, but is an estimation of my benefits.

_____ **Patient/Guardian Initials**

Assignment of Benefits/Authorization to Pay Benefits/Patient Financial Policy:
I authorize that any payment of eligible benefits by Insurance and/or Payor be made to CENTRAL TEXAS HEART CENTER, PLLC for any services provided to me. I understand that any medication refills that are requested outside of an office visit appointment could result in an additional fee. If 24 hour notice is not given to cancel an appointment, a verbal warning will be given, thereafter a fee of $100 for New Patient Appointments, $75 for Established Patient Appointments, $250 for Nuclear Imaging Appointments, $125 for Echo Appointments, and $250 for Vein Procedure Appointments will be assessed to your account. I agree to the terms of Central Texas Heart Center's Patient Financial Policy and am aware that a copy will be made available to me upon my request.

_____ **Patient/Guardian Initials**

Insurance Referral Policy:
I understand that it is my responsibility as the patient to ensure that any required approvals/authorizations/referrals, under the terms of my insurance contract, have been obtained prior to my receiving services. I also understand that my appointment may be rescheduled if the required approval is not received prior to my appointment date/time. Due to the ever changing policies and procedures outlined by Insurance companies, CTHC is compelled to notify all patients of this requirement even if my current insurance does not require such. I am aware that I may contact my Insurance company with any questions or concerns regarding this, as their policies and procedures can change at any time and often does. I also understand that if I decide to be seen without the required prior approval; my visit must be paid in full at the time of service and that it will be my responsibility to obtain reimbursement from my insurance company and that I may request the necessary claims information from CTHC to do so.
*CTHC's relationship with your insurance carrier requires us to notify you of such policies.

_____ **Patient/Guardian Initials**

Acknowledgement of receipt of Notice of Privacy Practices, Patient Portal Disclosure and Release of Health Information:
I agree to the terms of CTHC's notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information; and am aware that a copy will be made available to me upon my request. *Please note: Central Texas Heart Center providers are partnered with The Heart & Vascular Center.

_____ **Patient/Guardian Initials**

I grant the release of my medical and financial information, including access to my Patient Portal to the following person/s:

_____

Name: Email Address: Phone:

_____

Name: Email Address: Phone:

I agree to consent for detailed messages to be left at any and all of the contact phone numbers and/or emails listed above, as well as the release and access to my Patient Portal, healthcare and/or financial information to any and all of the contacts that I have provided above. By signing below, I verify that I have read and understand the aforementioned policies, guidelines, consents and authorizations.

_____ _____

Patient/Guardian Signature **Date**

Central Texas Heart Center PLLC

Central Texas Heart Center (CTHC): 979 - 774 - 4008

Address: 2700 E 29th St, in the CHI St Joseph Health Medical Office Building, Bryan, TX 77802

See black arrows on map for instructions on how to reach PATIENT / VISITOR parking lots P1 and P2

Suite 220: Drs. Mitchell, Schwartz and Wigley
Suite 235: Drs. Colato and Mays
Kyoko Arata, Nurse Practitioner
***** 2nd Floor *****

Suite 330: Dr. Gutierrez
Ellen Sugarek, Physician Assistant
*** **3rd Floor *****