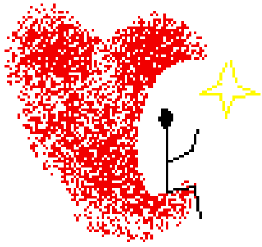


Pedi Cardio of West Texas

Cem Nasuhoglu, MD Pediatric Cardiology

Specializes fetus through young adult

Patient Registration Form

Patient

Last Name	First	Middle	DOB	Gender	Race	Ethnicity	Social Security #
Address	Apt.#	City		State		Zip Code	
Primary Phone#	Secondary Phone#	Preferred Pharmacy (City, Street, & Phone)				**E-Mail Address**	

Primary Care Physician

Doctor Name:	Address	City, State	Phone Number

Responsible Party

Mother Last Name	First	Middle	Social Security#	Date of Birth
Address	Apt. #	City	State	Zip Code
Employer Name	Address	Work Phone		Cell Phone
Father Last Name	First	Middle	Social Security#	Date of Birth
Address	Apt. #	City	State	Zip Code
Employer Name	Address	Work Phone		Cell Phone

Insurance

Primary Insured's Name	Address(if different from above)		Social Security #	Date of Birth
Insurance Company	Phone #	Policy Number	Group Number	Relationship to Patient

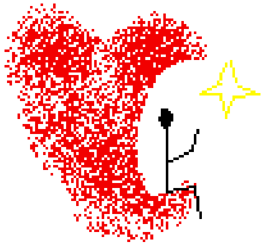
Emergency Contact

Name	Home Phone	Cell Phone	Work Phone	Relationship
Name	Home Phone	Cell Phone	Work Phone	Relationship

Authorized Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of medical benefits to the assigned Physician for services rendered. I understand that submittal of a claim is not a guarantee of payment and that I am financially responsible for all charges on this account.

Printed Name Signature Date

1909 W Wall Street, Suite B, Midland, Texas 79701-6510
Office Tel:(432)570-7334 Fax:(432)570-7339 www.pedicardio.com Info@pedicardio.com



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Consent for Treatment

I consent to and authorize testing and treatment as ordered by my doctor and his consultants, associates, and assistants. I authorize Pedi Cardio of West Texas nurses, employees and others as necessary to carry out the instructions of my doctor(s) with respect to the procedures and treatment he has ordered. I understand student nurses and others in professional training programs may be among the individuals who provide care to me.

No Guarantee: I acknowledge that no guarantees or warranties have been made to me with respect to treatment to be provided at Pedi Cardio of West Texas.

I give permission to Pedi Cardio of West Texas to file any claim to my insurance company and to accept assignment of any benefits paid. I also understand if my insurance fails to pay a claim for any reason other than Provider Discount that I will ultimately be responsible for payment, since the contract is between my insurance company and me.

If the patient is a minor: I affirm I am the parent or legal guardian of this patient with full authority to give consent for him/her to be tested and treated.

______________________________	______________________________
Printed name of patient	Date
______________________________	______________________________
Signature of patient/parent/legal guardian	Printed name of parent/legal guardian

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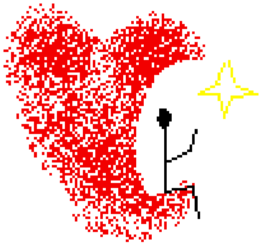

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All patients must complete our "Patient Information Form" before seeing the doctor.

Regarding Insurance

We may accept assignment of insurance benefits if your deductible has been satisfied. However, we do require that you pay your percentage that is your responsibility according to your policy at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. If your insurance has not paid in full within 45 days, the balance will be automatically transferred to your responsibility and payment is expected within 30 days of receiving your statement. Please be aware some and perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare Program and/or other Medical Insurance.

UCR (Usual and Customary Rates)

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this Financial Policy:

X____Date: __________________

Signature of Patient or Responsible Person

Insurance Authorization

I hereby Authorize Dr. Cem Nasuhoglu to furnish information to my insurance carrier concerning my illness and treatments.

X____Date:____________________

Signature of Patient or Responsible Person

Assignment of Benefits

I hereby assign to the physician Dr. Cem Nasuhoglu all payment for medical services rendered to myself, or my dependents. I understand that I am responsible for any amount not covered by my insurance.

X____Date:____________________

Signature of Patient or Responsible Person

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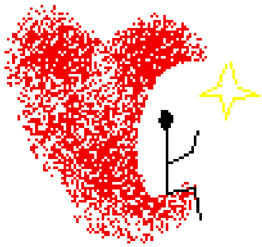

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NOTICE OF PRIVACY PRACTICES

We are required to provide you with our "Notice of Privacy Practices". Please review this information. Return the completed coversheet to the receptionist. You may keep the attached Notice or return it along with the coversheet.

Please provide the information below.

____ ______________________

Your Name (Patient) please print Date of Birth

I have been provided with a copy of the "Notice of Privacy Practices".

____ _____________________

Signature (Patient or Personal Representative) Date

May we leave medical information on your "home" answering machine? Yes____ No _____

May we leave appointment information on your "home" answering machine? Yes ____ No ____

May we e-mail you medical and appointment information? Yes ____ No ____

May we text message appointment information? Yes _______ No _______

Text message provider AND phone number: ____

____

____

Please list below the names, relationship, and phone number of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical information with.

Name **Relationship** **Phone Number**

1.____

2.____

3.____

__________________________________ _____________________

Signature of Patient/Parent/Legal Guardian Date

Or

If you do not want any of your medical or financial information discussed with anyone other than yourself please sign below.

____ ____________________

Signature of Patient/Parent/Legal Guardian Date

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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.

This practice uses and discloses health information about you for your treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed below.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment, we may request that your primary are physician share your medical information with us. Also, we may provide your primary care physician about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. Or if we refer you to another specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you that you're insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information to bill and collect payment for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

These are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births or death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of productions they may be using.

850 Tower Drive Suite # 112 Odessa, TX 79761
Office Tel:(432) 332 0052 Fax:(432) 3328082 www.pedicardio.com Info@pedicardio.com

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Office Tel:(432)570-7334 Fax:(432)570-7339 www.pedicardio.com Info@pedicardio.com

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections wich are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may relate to criminal conduct;
- Is about a victim and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on the premises; or
- Is released to locate a fugitive, missing person,or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation

We may disclose your medical information as required by the Texas worker's compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence activities, Protection of the President

We may disclose your medical information for specialized government functions such as separation or discharge from the military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law

Your Right Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing. (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only responsible request. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to particular place, the contract/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designed record set, wich is information that is used to make decisions about your care. Texas requires that request for copies that be made in writing and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed below.

Public Health, Abuse or Neglect, and Health Oversight

We can refuse to provide some of the information you ask to inspect or ask to inspect to copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or narrative within fifteen days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to discharge a reasonable cost base fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the fees permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not a part of the Designated Record Set.
- Is not available for inspection because of appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a partial statement about the information at issue in our medical records. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing and allow the amendment to be made and tell others that we know that have incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting or disclosures that are other than for treatment, payment, health care operation, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional request within that period, we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives and Other Health Related Benefits

We may contact you by telephone or mail to provide appointment reminders, information about treatment alternatives or other health related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Human Services is:

U.S Department or Human Services, Atten: HIPAA Complaint
7500 Security Blvd. C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulations to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person For Request

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Cem Nasuhoglu, MD
850 Tower Drive #112
Odessa Texas, 79761
(432)332-0052/ (432)332-8082

This notice is effective on the following date: April 5, 2003

We may change our policies and this notice at any time and have those revised policies apply to all the health information we maintain. If or when we change our notice, we will post the new notice in the office.