ANDRES MESA, M.D., FACC, FASE, FASCAI
6624 Fannin, Suite 2320 – Houston, TX 77030

REGISTRATION 1

NAME:_____AGE_____Sex M F
Date:_____Height:_____Birth Date_____
Marital Status : M S D W Referred by: _____

Reason for visit:_____
_____
_____

Cicle any of the following known problems:
Heart attack year(s)_____
Angina ? many yrs_____
Heart murmur discovered in _____
Palpitations
Fainting
Chest pains: occasional frequent
Shortness of breath
Heart failure: ? many years_____
Leg cramps walking ? many years_____
Blue fingertips or toes

Circle any previous testing done: add dates?
Stress test_____
Nuclear stress test_____
Stress echocardiogram_____
Regular echocardiogram_____
EKG within past 6 months_____
Heart catheterization_____
Heart bypass surgery_____
Heart artery balloon stents_____
Leg artery balloon/stents_____
Neck artery balloons, stents, or surgery_____
Leeg artery surgery_____
Pacemaker or defibrillator_____
Heart electrical procedures (ablation, surgery)_____
Heart valve surgery_____

Circle any known heart risk factors:
High Blood pressure Y N Years____
High cholesterol:_____ Years____
High triglycerides:____ Years____
High blood sugar(diabetes) Years____
Active smoker Years____
Previous smoker
Overweight
Alcohol usage: occasional treatment

FOR WOMEN:
Are you pregnant now Y N
Have you reached menopause Y N

Leisure Activities:
_____
_____
_____

Education Level:_____

With whom do you live:_____
_____

Known family history of heart disorders
M:↑↓@ _____yrs old;
Cause_____
F:↑↓@_____yrs old;
Cause:_____
Other family health disorders:_____
_____
_____

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REGISTRATION 2

NAME:_____**OCCUPATION**_____

Circle any of the following problems you can identify with your own health

HEENT- ringing in the ears, dizzy spells, fainting, glaucoma, double or blurry vision, sinusitis, cataracts, nosebleeds, recurring sore throat, ear infections, heart loss
RESPIRATORY- pneumonia, pleurisy, bronchitis, tuberculosis, cough, asthma, wheezing, hay fever, coughing up blood, shortness of breath
VASCULAR- irregular pulse, phlebitis, stroke, varicose veins, high blood pressure
GI- can't eat, hard to swallow, heartburn, ulcers, nausea, vomiting, abdominal pain, gallstones, jaundice, diarrhea, bloody stools, diverticulitis/osis, constipation, hemorrhoids, hepatitis, hiatal hernia
GU- nighttime urination, burning urination, kidney stones, bloody urine, venereal diseases, can't hold urine (leaking), enlarged prostate
ENDOCRINE- weight loss-gain, diabetes, hypo-hyper-thyroid (it is), low blood sugar
HEMATOLOGY- anemia, bleeding disorders, bruising, lymphoma, leukemia
NEUROLOGY- tremors, numbness, tingling, headache, memory loss, nervousness, seizures, migraines, paralysis of a limb
MUSCULOSKELETAL- arthritis, joint aches, muscle pains, back pain, gout, osteoporosis
GENERAL- leg swelling, rashes-itching, depression, caffeine-abuse, mental illness, anxiety, hoarseness, fatigue, insomnia, loss of appetite, breast lumps
CANCER OF- lungs, breast, bone, prostate, colon, uterus, +HIV

_____

List all medications being taken, dosage, how many per day

List any known previous operations:

_____

List any medical hospitalizations:_____

_____

Medications Allergies: Y/N;
Describe_____

CARDIOLOGY ASSOCIATES, P.A.

C. S. SUNG, M.D. SURENDRA K. JAIN, M.D. DONALD TRILLOS, M.D. ANDRES MESA, M.D.

6624 FANNIN - SUITE 2320
HOUSTON, TEXAS 77030
713-797-1111
FAX 713-790-0008

PATIENT ACCOUNT NUMBER: _____

PATIENT INFORMATION *(PLEASE PRINT)*

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP

STRET ADDRESS OR VICINITY (In event of an emergency)

TELEPHONE NUMBER ( )	NAME OF SPOUSE (If applicable)

FOREIGN ADDRESS

DRUG ALLERGIES, IF ANY	MARITAL STATUS (S / M / W / D / Sep.)	DO YOU SMOKE?	DIABETIC?	PREVIOUS HEART SURGERY?	PACEMAKER?

MEDICATIONS: LIST ANY MEDICATIONS YOU TAKE DAILY, INCLUDE FREQUENCY AND AMOUNTS

REFERRING PHYSICIAN'S NAME	ADDRESS	PHONE ( )

PATIENT'S EMPLOYER	SPOUSE'S EMPLOYER
BUSINESS ADDRESS	**BUSINESS ADDRESS**
BUSINESS PHONE ( )	**BUSINESS PHONE** ( )

IN CASE OF EMERGENCY CONTACT: (Name of friend or relative not living with you.)

LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	HOME PHONE ( )
ADDRESS, CITY, STATE, ZIP				BUSINESS PHONE ( )

HEALTH INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	MAILING ADDRESS OF INSURANCE COMPANY		PHONE
POLICY NUMBER OR CERTIFICATE NUMBER	GROUP NUMBER	NAME OF POLICY HOLDER	RELATION
NAME OF INSURANCE COMPANY	MAILING ADDRESS OF INSURANCE COMPANY		PHONE
POLICY NUMBER OR CERTIFICATE NUMBER	GROUP NUMBER	NAME OF POLICY HOLDER	RELATION
NAME OF INSURANCE COMPANY	MAILING ADDRESS OF INSURANCE COMPANY		PHONE
POLICY NUMBER OR CERTIFICATE NUMBER	GROUP NUMBER	NAME OF POLICY HOLDER	RELATION

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR PAYMENT OF DOCTOR'S FEES WITHIN 30 DAYS REGARDLESS OF INSURANCE COVERAGE OR STATUS OF INSURANCE CLAIM(S). EXTENSION OF CREDIT BEYOND 30 DAYS MUST BE DISCUSSED AND APPROVED BY THE BUSINESS OFFICE IN ADVANCE. INSURANCE PAYMENTS RECEIVED WILL BE APPLIED TO YOUR ACCOUNT BALANCE OR PROMPTLY REFUNDED TO YOU. NECESSARY FORMS WILL BE COMPLETED AND FORWARDED TO THE ABOVE INSURANCE COMPANIES IN ORDER TO EXPEDITE INSURANCE CARRIER PAYMENTS.

INSURANCE AUTHORIZATION AND ASSIGNMENT *(PLEASE READ AND SIGN)*

I HEREBY AUTHORIZE CARDIOLOGY ASSOCIATES, P.A. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

SIGNATURE DATE

_____ _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me by Cardiology Associates, P.A.

Signed: _____ this _____ day of _____, 200 ____.

For Office Use Only:
If not signed, reason why acknowledgement was not obtained: _____

Person seeking acknowledgement: _____ Date: _____

Cardiology Associates, P.A.

6624 Fannin, Suite 2320
Houston, Texas 77030
713.797.1111

JOINT NOTICE OF PRIVACY PRACTICES

(INDIVIDUAL AND GROUP)

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 Notice describes the privacy practices of Cardiology Associates, P.A. and the physicians who provide services to patients at these facilities.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations

- **Treatment**: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
- **Payment:** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
- **Health Care Operations:** We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- **Required by Law:** We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- **Public Health Activities:** As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- **Health oversight:** We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- **Judicial and administrative proceedings:** We may disclose information in response to an appropriate subpoena or court order.
- **Law enforcement purposes:** Subject to certain restrictions, we may disclose information required by law enforcement officials.

(continued on reverse)

- **Deaths:** We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- **Serious threat to health or safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Military and Special Government Functions:** If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- **Research:** We may use or disclose information for approved medical research.
- **Workers Compensation:** We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, 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 to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

- **Request Restrictions:** You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
- **Confidential Communications:** You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
- **Inspect and Obtain Copies:** In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
- **Amend Information:** If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
- **Accounting of Disclosures:** You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Linda Cantu
6624 Fannin, Suite 2320
Houston, TX 77030
713.797.1111

Independent Contractors:

Cardiology Associates, P.A. and the physicians who practice here are independent contractors and do not hereby assume any liability for the services or conduct of the other.

Effective Date:

The effective date of this Notice is April 14, 2003.