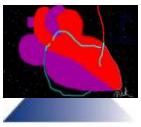

SUGAR LAND HEART CENTER

16659 S.W. FWY #361 SUGAR LAND, TX 77479 PHONE: (281) 265-7567 FAX: (281) 265-4565

S.G. (NIK) NIKAM, MD, MHA, DTM
Interventional Cardiologist

PATIENT REGISTRATION FORM

NAME:_____D.O.B.:_____SEX:_____DATE:_____

ADDRESS:_____SS#:_____

CITY:_____ ST:_____ZIP:_____PHONE:_____

INSURED EMPLOYER: _____ HOME PHONE:_____

BUSINESS PHONE : _____ MOBILE PHONE:_____

PRIMARY PHYSICIAN:_____PHONE:_____

REASON For REFFERAL:_____

EMERGENCY NAME:_____MOBILE_____

INSURED NAME:_____PT .REL:_____PHONE:_____

ADDRESS:_____

D.O.B:_____ SEX:_____ SS#:_____

PHARMACY NAME:_____ PHARMACY PHONE:_____

I hereby authorize Dr. Nikam to perform a physical examination on me, including tests to determine the state of my health. I authorize the release of any medical information that is necessary to process this claim. I also authorize payment of medical benefits directly to the physician. Your payment or Co-Pay is due at the time of service.

SIGNATURE:_____ DATE:_____

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Present History

Patient: _____ **Age:** ___ **Sex:** ___ **Date:**_____

Chief complaint		
Main Symptom	**Describe fully**	
Chest pain	YES NO	
Location		
Duration		
Frequency		
Radiation to arm or shoulder		
Aggravating factors		
Relieving factors		
Shortness of breath (SOB)	YES NO	
	With mild exertion With moderate exertion With severe exertion At rest	
	SOB at night	
Palpitations		
Rapid heart beat		Skipping of heart beats
Irregular heart beat		Fluttering
Dizziness & Blackout	Y / N	
How often		
Does the room spin	Y / N	
Ringing in the ears	Y / N	
Blackout	Y / N	
Heart attack:		
How many	When:	Where:
Stress test	Date:	Result:
Cardiac Catheterization:	When:	Where:
Coronary stents:	When:	Where:
Pacemaker: year:		Company:
Heart failure:		
Leg cramps/ Leg swelling	Y / N	
Past Medical History		
Hypertension **HTN**	Y / N	
Diabetes **DM**	Y / N	
High Cholesterol L**IPIDS**	Y / N	
Congestive Heart Failure-**CHF**	Y / N	
Coronary Artery Disease **CAD**	Y / N	
Kidney Failure **CKD**	Y / N	
Anemia	Y / N	
Operations:	Y / N	
Hospitalizations:	Y / N	
Hypothriodism	Y / N	

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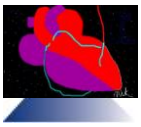
Review of Systems

Patient: _____ **Age:** ___ **Sex:** ___ **Date:**_____

		Description			
			Kidney:		
Family History			Kidney failure	Y / N	
Hypertension- **HTN**	Y / N		Kidney stones	Y / N	
Diabetes-**DM**	Y / N		Dialysis	Y / N	
Congestive Heart Failure-**CHF**	Y / N		Others	Y / N	
Heart Attack -**AMI**	Y / N		UTI	Y / N	
Kidney Failure-**CKD**	Y / N		Frequency	Y / N	
Cancer	Y / N				
Coronary Artery Dis -**CAD**	Y / N		**Arterial**	Y / N	
			Poor circulation	Y / N	
Personal and Social			Varicose veins	Y / N	
Smoking	Y / N		Pain on walking	Y / N	
Alcohol	Y / N		Ulcer	Y / N	
Caffeine	Y / N		Discoloration	Y / N	
Stress home/work	Y / N				
Spouse/Children	Y / N		**Musculoskeletal**		
	Y / N		Muscle aches	Y / N	
General			Arthritis	Y / N	
Weight change	Y / N		Leg Cramps	Y / N	
Weakness	Y / N		Gout	Y / N	
Fatigue	Y / N				
HEENT			**Neurological**		
Headache	Y / N		Stroke	Y / N	
Dizziness	Y / N		TIA	Y / N	
Sinus infection	Y / N		Tingling	Y / N	
Neck Pain	Y / N		Numbness	Y / N	
Enlarged Thyroid	Y / N		Seizures	Y / N	
Pulmonary			**Medicines**	**Dose**	**Frequency**
Asthma, allergies	Y / N		**1**		
Bronchitis	Y / N		2		
Emphysema	Y / N		3		
Others	Y / N		**4**		
			5		
Gastrointestinal			6		
Stomach upset	Y / N		7		
Peptic Ulcer	Y / N		8		
Gall stones	Y / N				
Diverticulosis	Y / N				
Bleeding	Y / N				



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Acknowledgement of Receipt of Notice of Privacy Practices
You may refuse to sign this acknowledgement.

I have received a copy of this office's Notice of Privacy Practices.

_____	_____	_____
Please Print Name	Signature	Date

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You are entitled to a copy of this consent after you sign it. The original will be kept in your chart.

Consent: I have had full opportunity to read and consider the contents of this consent form and the notice of privacy practices for Sugar Land Heart Center. I understand that by signing this consent form, I am giving my consent for use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____	_____	_____
Please Print Name	Signature	Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____
_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how Sugar Land Heart Center, its medical staff members, and employees, may use and disclose your protected health information (PHI) for purposes of treatment, payment and health care operations, and for other purposes that are permitted or required by law.

OUR RESPONSIBILITIES: Sugar Land Heart Center (**SLHC**) takes the privacy of your health information seriously. We are required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. We will abide by the terms of this Notice of Privacy Practices. We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain. Any new Notice of Privacy Practices adopted will be posted in the Patient Registration area, and made available at your next appointment.

Protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

Health care operations include activities such as communications among heath care providers, conducting quality assessment and improvement activities; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; contracting with insurance companies: conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

HOW IS MEDICAL INFORMATION USED? SLHC uses medical records as a way of recording health information, planning care and treatment and as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that we are required to submit in order to bill for treatment we provide to the patient. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of Sugar Land Heart Center.

V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Medical information may be used to justify needed patient care services, (i.e., lab tests, prescriptions, treatment protocols, research inclusion criteria).

We will use medical information to establish a treatment plan.

We may disclose protected health information to another provider for treatment (i.e. referring physicians, specialists and providers at **SLHC**.)

We may submit claims to your insurance company containing medical information and we may contact their utilization review department to receive pre-certification (prior approval for treatment).

We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.

We may contact you to remind you of the patient's appointment by calling you or mailing a postcard.

We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.

WHY DO I HAVE TO SIGN A CONSENT FORM? When you, as the patient or the parent or guardian of a patient, sign a consent form, you are giving **SLHC** permission to use and disclose protected health information for the purposes of treatment, payment, and health care operations. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment or healthcare operations.

CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION? You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point, or (2) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

YOUR PRIVACY RIGHTS The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your health information. This means you may inspect and obtain a copy of your PHI that is contained in a "designated record set" for so long as we maintain the PHI. A designated record set contains medical and billing records and any other records that Sugar Land Heart Center uses in making decisions about your healthcare. You may not however, inspect or copy the following records: psychotherapy and psychosocial notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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2. You have the right to request a restriction of your health information. This means you may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment or healthcare operations. Sugar Land Heart Center is not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting our Privacy Officer.

3. Your have the right to request to receive confidential communications by alternative means or at alternative locations. We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the request. Requests must be made in writing to our Privacy Officer.

4. You have the right to request amendments to your health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with our Privacy Office and we may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact our Privacy Officer. Requests for amendment must be in writing.

5. You have the right to receive an accounting of disclosures of your health information. You have the right to request an accounting of certain disclosures of your PHI made by **SLHC**. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

WHAT IF I HAVE A QUESTION / COMPLAINT? If you have questions regarding your privacy rights, please contact the **SLHC** Privacy Officer at (281) 265-7567. If you believe your privacy rights have been violated, you may file a complaint by contacting the **SLHC** Privacy Officer (281) 265-7567, or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. The address for the Secretary of the Department of Health and Human Services is:

Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone 214-767-4056
FAX 214-767-0432
TDD 214-767-8940
To e-mail the DHHS Secretary or other Department Officials, send your message to hhsmail@os.dhhs.gov.