Cardiovascular ar **ices of Lubbock**

Patient Name: _____ Today's Date: _____

Patient Information

SSN: _____ **Date of Birth:** _____

Gender: ___M **or** ___F **Marital Status:** ___ Single ___Married ___Widowed ___Separated ___Divorced

Ethnicity: _____Hispanic, Latino, or Spanish Origin ***OR*** ____Not Hispanic, Latin, or Spanish Origin

Race: _____Asian _____Black/African American ____Caucasian/White ____Hispanic

_____Native American/Alaskan Native ____Native Hawaiian/Pacific Island ____Other ___Refuse

Mailing Address: _____**City:** _____

State: _____ **Zip:** _____ **Home Phone:** _____ **Cell:** _____

Skilled Nursing Facility: ___Yes or ____No **Facility Name:** _____

Email: _____

I consent to receive notification via text, email or post mail with the information given above.

Primary Physician: _____ **OB/GYN *(if applicable):*** _____

Referring Physician: _____

Preferred language: ___English ___Spanish ___Sign Language ___Other: _____

Emergency Contact Information

Emergency Contact Name: _____ **Phone:** _____

Emergency Contact Relationship: _____ **Date of Birth** _____/____/ _____

Patient Employee Information

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD
4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Employment Status: ___Employed ___Not Employed ___Self Employed ___Student ___Retired

Other: _____

Employer Name: _____ **Work Phone:** _____

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Policy Holder Information

Name: _____ **SSN:** _____

Date of Birth: ____/____/_____ **Patient's Relationship to Policy Holder:** _____

Mailing Address: _____**City** _____ **St:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____

Employer Name: _____ **Work Phone:** _____

Employer Address: _____**City** _____ **St:** _____ **Zip:** _____

Insurance Information

Primary Insurance Name: _____**ID/Policy Number:**_____

Group Number: _____ **Insurance Phone Number:**_____

Secondary Insurance Name: _____**ID/Policy Number:**_____

Group Number: _____ **Insurance Phone Number:**_____

Tertiary Insurance Name: _____**ID/Policy Number:**_____

Group Number: _____ **Insurance Phone Number:**_____

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Signature: _____ **Date:** _____

Medicare And/or Medicaid Certification

The person signing below certifies that he/she has read this document and is the patient or is duly authorized by the patient as the patient's representative, to execute the above and accept its terms.

"I certify that the information given by me in applying for payment under Title XVII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers any information for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf."

Patient name: _____

Signature:_____ **Date:** _____

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

I understand that as part of my healthcare, My Provider originates and maintains medical records describing my health history, symptoms, examination and test results, diagnosis, treatment, financial and demographic information, and any plans for future care or treatment. My Provider also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes.

- Planning my care and treatment
- Communication between My Provider and healthcare professionals that act under the direction of My Provider and participating in my diagnosis, evaluation, or treatment.
- Collection of fees for medical services
- Determining liability for payment and obtaining reimbursement
- Conducting healthcare operations, including the evaluation of healthcare services, appropriateness and quality of healthcare treatment, and the qualifications of healthcare practitioners.

I can request a copy of the Physician's *Notice of Privacy Practices* that provides information about how the Physician uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to view the notice prior to signing this consent; and
- The right to request restrictions as to how my health information may be used or disclosed to conduct treatment, payment, or healthcare operations. The Physician is not required to agree to the requested restrictions but is bound to any restrictions agreed to.

I understand that as provided in the *Notice of Privacy Practices,* the terms of *Notice* may change. If they do, I may obtain a revised copy from the Privacy Officer by calling (806) 516-5922.

I understand that I may revoke this consent in writing, except to the extent that the Physician has already acted in reliance thereon. I understand that by refusing to sign or revoking this consent, the Physician may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows:

_____
_____
_____

I understand that my confidential information may be released to the following individuals:

_____
_____
_____

_____
_____

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Signature of Patient or Representative Date

_____

Patient Name

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Patient Financial Responsibility

We are committed to providing you with the best possible cardiac and medical care: if you have special needs, we are here to collaborate with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time of services provided. For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express
2. Our office participates in a variety of insurance plans. It is your responsibility to:

    a. Bring ALL your insurance cards at EVERY visit.

    b. Be prepared to pay your co-payment, co-insurance, and/or deductible at each visit. Payment can be made by cash, check, or credit card.

    c. For medical care not covered, deemed medically unnecessary or deemed cosmetic by your insurance company, payment in full is due at the time of your visit.

3. If you have insurance that we do not participate in, our office is happy to file a claim upon request; however, payment in full is required at the time of service. A deposit will be required for all surgeries.
4. If the total patient balance due cannot be paid in full, arrangements must be made PRIOR to services being rendered. Failure to plan with Cardiovascular and Arrhythmias Services of Lubbock (CASL Health) will result in the immediate collection turnover or payment in full.
5. **Referrals**: It is **YOUR RESPONSIBILITY** to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you will be financially responsible for all services rendered,
6. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals and insurance card(s).
7. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department.
8. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collection agency. If you consistently refuse to pay for your services rendered, CASL Health may choose to cease providing services to you.
9. I understand that I am responsible for any health insurance deductible and coinsurance **at the time services are rendered.**

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Our practice passionately believes that a good physician/patient relationship is based upon understanding and honest communication. Questions about financial arrangements should be asked prior to services being provided.

Signature:_____ **Date:** _____

CASL HEALTH

Consent to Treatment

I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) give permission for medical treatment, including radiology and laboratory procedures, to be performed by the physicians and staff of Aurelio Cervera, MD, PA doing business as CASL Health. This consent is valid from this date forward.

Providers consent.

I acknowledge that I am aware my provider is either **Dr. Aurelio Cervera, Dr. Mohammad Hassan** and/or **Jennifer Schmoker.**

Agreement as to governing law and forum

The patient or patient's representative and health care provider, including employees and agents of the healthcare provider, rendering or providing medical care, health care, or safety, professional or administrative services directly related to the health care of the patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in Texas Court in the county/district where all or substantially all of the healthcare was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Assignment of benefits:

In consideration of services rendered, I hereby assign CASL Health and/or any physician who has treated me, all rights, title, and interest in any payment due for services described herein as provided in the policy or policies of insurance. I agree to pay the charges of CASL Health and/or attending which is greater than the amount paid by insurance company or companies.

Advance Directive/Living Will:

Do you have an Advance Directive/Living Will? ____Yes ____No

If you answered No, please contact your Attorney or Primary Care Physician for more information.

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Patient name:_____

Signature:_____ **Date:** _____

Initial Clinical History and Physical Form

Date of Visit: _____ **Name:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Preferred Gender:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Reason For Visit:

_____

_____

_____

Past Medical History

(please check any of the following that you have been diagnosed with)

___ Coronary Artery Disease

___ Hypertension

___ Rheumatic Fever/Heart Disease

___ Enlarged Heart

___ Myocardial Infraction (Heart Attack)

___ Stroke/TIA

___ Type 1 Diabetes

___ Hypothyroidism

___ Kidney Disease

___ HIV

___ AFIB

___ Congestive Heart Failure

___ Heart Murmur

___ Palpitations

___ Claudication (Leg Cramps w/ Exercise

___ Sinus Node Dysfunction

___ Type 2 Diabetes

___ Hyperthyroidism

___ Sleep Apnea Do you wear a CPAP? _____

___ Hepatitis A B or C

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

___ COPD

___ Ventricular Dysfunction Symptoms # of Pillows to Sleep ____

___ Waking Up Shortness of Breath

___ Tiredness/Fatigue

___ Pedal Edema (Swelling of feet and/or legs)

___ Orthopnea (difficulty breathing lying down)

___ Ventricular Tachycardia

___ Long QT Syndrome

___ Brugada Syndrome

___ Syncope (passing out)

___ Atrial Flutter

___ Premature Ventricular Complexes (PVC)

___Premature Atrial Contractions (PAC)

___ Emphysema

___ Asthma

___ Seizures

Other:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Do you have Chest Discomfort? ___**Yes** ___ **No**

Date of Onset
_____
___

What part of your chest hurts?
_____

What kind of pain (dull, ache. Stabbing, etc.)?
_____

What causes it to hurt? (exercise, etc.)
_____

How long does it last?
_____

Accompanied by any other symptoms?
_____

What stops the pain?
_____

How often do you the pain?
_____

Current Medications

Prescribed Medications	Dosage	How often do you take it (daily, twice daily, etc.)

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Non-Prescribed Medications	Dosage	How often do you take it (daily, twice daily, etc.)

Allergies:

Medications:

_____

_____

Foods:

_____

_____

Other:

_____

_____

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

History of procedures/studies (Please check the following Procedures/Studies you have done. If you have not had any of the following, then please proceed to the next page)

__ None of the Below

__ Heart Catheterization	Date:	Place of Treatment:
__ Coronary Angioplasty	Date:	Place of Treatment:
__ Coronary Artery Bypass	Date:	Place of Treatment:
___ Stress Test	Date:	Place of Treatment:
___ Echocardiogram	Date:	Place of Treatment:
___ Holter Monitor	Date:	Place of Treatment:
___EBT	Date:	Place of Treatment:
___ Carotid Doppler	Date:	Place of Treatment:
___ Lower Extremity Doppler	Date:	Place of Treatment:
___ Bypass/Angioplasty/Stent in other places	Date:	Place of Treatment:
___ Dual Chamber Pacemaker	Date:	Place of Treatment:
___ Single Chamber Pacemaker	Date:	Place of Treatment:
___ Watchman Device	Date:	Place of Treatment:
___ILR Implant	Date:	Place of Treatment:
__ TEE	Date:	Place of Treatment:

Other Surgical History (In Your Lifetime)

Name of Surgery:	Date:

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Social /Personal History

Current Residence (City/State)

Occupation: _____

Any Current Tabacco Use: __Yes __No

Any Past Tabacco Use: __ Yes __No

Type of Tabacco Used: _____

# of cigarettes/pack per day/week: _____

How Many Years: _____

Stopped using Tabacco when: _____

Any Alcohol Use? __Yes __No

How much/How Often? _____

Any Caffeine Use? __Yes __No

How much/How Often? _____

Any Recreational Drugs? __Yes __No

How much/How Often? _____

Do you Exercise? __Yes __No

How much/How Often? _____

Do you have any religious restrictions? _____

Family History (any illnesses/medical issues that your family members have has)

Family Member (mother, father, etc.)	***Illness/medical issues (high blood pressure, heart disease/issues, high cholesterol, diabetes, cancer, etc.)***

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315

Aurelio Cervera, MD
Jennifer Schmoker, FNP-C
Mohammad Hassan, MD

4316 23RD Street Lubbock TX 79410
Ph: 806-516-5922 Fax:806-853-9315