# *METRO NORTH CARDIOVASCULAR ASSOCIATES, P.A.*

*Max Garoutte, M.D.*

Date: _____

Referring Physician (Surgeon, if applicable): _____ PH Number: _____

Primary Care Physician: _____ PH Number: _____

Patient Name: _____
Last First M.I. Nickname

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

SS#_____ D.O.B: _____ Age: _____ Male: _____ Female: _____

Occupation: _____ Active:___ Retired: ____ Disabled: ____ Part-Time: ____

Employer's Name: _____ Work Number: _____ Ext. _____

E-Mail: _____

Spouse's Name: _____ Spouse's SS#: _____

Spouse's D.O.B: _____ Spouse's Cell Number: _____

Spouse's Employer: _____ Work Number: _____ Ext: _____

Occupation: _____ Active: ___ Retired: ___ Disabled: ___ Part-Time: ___

**********

Nearest Relative Living at a different address: Name: _____

Nearest Relative's Phone Number: _____ Relation to you: _____

Okay to release medical information to: _____

Relation to you: _____ Phone Number: _____

**********

Name of Primary Insurance Company: _____ PPO___ HMO___

Phone Number: _____ Complete Address: _____

_____ Group#: _____ Policy/ID#: _____

Name of Secondary Insurance Company: _____ PPO ___ HMO ___

Phone Number: _____ Complete Address: _____

_____ Group#: _____ Policy/ID#: _____

Primary Card Holder's D.O.B.: _____ Primary Card Holder's SS#: _____

*Metro North Cardiovascular Associates, P.A.*

*Max Garoutte, M.D.*

**Patient Name:** _____ **D.O.B.:**_____

**Reason(s) for Office Visit:**

_____

_____

_____

**Name of Preferred Pharmacy:** _____ **Phone#:** _____

**Location/City/Zip code:** _____

**What medication(s) are you allergic to and what was your reaction to the drug:** _____

_____

**Please list all prescription medications that you are currently taking. Also list all vitamins, minerals and over the counter medications such as Advil, Aspirin, Laxatives, Allergy medicines, etc.**

| Name of Medication | Dose/Mg/Unit | How many tablets per day? | Reason |
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**List all Surgeries (From birth to present day), including dates or approximate dates, if available:**

_____

_____

_____

## Do you have a history of having had or been treated for any of the following:

**Please check all that apply**

AIDS___ If so, when? _____

Alcohol Dependency___ If so, when? _____

Allergy Syndrome___ If so, when? _____

Alzheimer's___ Onset, when? _____

Anemia (Low iron in the blood) __ If so, when? _____

Angina (Stable Chest Pain) __ If so, when? _____

Anorexia ___ If so, when? _____

Anxiety___ If so, when? _____

Arthritis (What kind) _____ If so, When? _____

Asthma ___ If so, when? _____

Atherosclerotic Heart Disease ___ If so, when? _____

Bradycardia__ If so, when? _____

Benign Prostatic Hypertrophy__ If so when? _____

Bronchitis ___ If so, when? _____

Acute____ or Chronic____

Bulimia ___ If so, when? _____

Cancer___ What kind_____ When _____

Cardiac arrhythmia (Type) _____ When_____

Cardiac Pacemaker(Brand) _____ When _____

Reason for Pacemaker_____

Cataracts ___ Which eye _____ When _____

Cerebrovascular accident or Stroke ____ When _____

COPD ___ Use Oxygen ____ When_____

Cirrhosis of the liver ___ When _____

Congestive Heart Failure___ When_____

Constipation___ When_____

Depression ___ When _____

Diabetes I __II __When_____

Gall Stones ___ When _____

GERD ___ When _____

Goiter (Lg Thyroid) __ When _____

Hearing Impairment ___ When _____

Hepatitis ___ When _____

Hypercholesterolemia__ When _____

Hypertension__ When _____

Hyper/Hypothyroidism __ When ____

Kidney Disease __ When _____

Mental Disorder __ What type_____

Murmur (Heart) __ When_____

Myocardial Infarction ___ When____

Peripheral Vascular Disease___

Phlebitis __ When_____

Pneumonia___ When_____

Rheumatic Fever ___ When_____

Seizure Disorder ___ When_____

STD____ Type_____

Stress Syndrome ___ When _____

Suicide Attempt__ When_____

Tuberculosis__ When_____

Varicose Veins__ When_____

Vertigo__ When_____

Other:_____

_____

_____

**Father: Alive___ Deceased ___ Age at Death___ Reason**_____

**Health History**_____

**Mother: Alive__ Deceased__ Age at Death___ Reason** _____

**Health History** _____

## CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

**Chest Pains: Y___ N___** **If Yes, where (location):** Right Side ____ Center (Sternum) ____ Left Side____ Back Pain (Between shoulder blades) ___Arm Pain___ Which Arm____ Neck/Jaw___ Mid-Epigastric___

**Type of Pain:** Squeezing___Tightness___Burning___Pressure___Sharp___Indigestion-like___

Heaviness___ Needle-like___ Achy/Gnawing___

**Does it Radiate: Y___N___** **Where does it radiate to:** _____.

**Duration of Pain:** ___ Days ___Weeks ___ Months ___ Year(s) **Severity: Mild___ Moderate___ Severe___**

**How long does the pain last:** ___Second(s) ___Minute(s) ___ Hour (s)

**Shortness of Breath: Y___N___** **When:** At rest___ With Exertion (activity) ___ With Stress___

**Use of supplemental oxygen: Y___ N___ If yes, : ___ LPM Continuous__ or At bedtime___**

**Palpitations: Y___N___** **If Yes, Where (location):** Right Side___ Center___ Left Side___

**Type:** Racing___ Pounding___ Fluttering___ Irregular or Unsteady___ Slower than Normal____

**When:** At rest___ With or After Exertion (activity) ___ While laying down___ When Stressed___

**Abdominal Pain: Y__N__ If yes, explain:** _____

_____

**Check all recent symptoms that may apply:**

Fatigue___ Dizziness___ Fainting___ Anxiety___ Insomnia___ Sleep Apnea___, CPAP Y__ or N__ Nausea___ Sweating____ Lower (chronic) Back Pain___ Leg Pain___ Edema___ Headaches___

**Cardiac Risk Factors:** Smoking___ High Blood Pressure___ Diabetes Mellitus___ High Cholesterol___

Family History of Coronary Artery Disease___ Explain: _____

_____.

**Do you have any problems with the following:**

Walking___ Explain: _____. Bathing___ Explain: _____

Housework___ Explain:_____ Driving___ Explain: _____

Taking medication___ Explain:_____ Standing for long periods__ Explain_____

**Are you claustrophobic: Y__ N__**

**Habits: Tobacco: Y___.N___. Number of Packs per day___ Other:** _____

**Alcohol: Y___N___ Daily Consumption:_____ Illicit Drugs Use: Y___N___**

**Drugs Used:**_____

**Is there any reason you would not be able to walk on a treadmill, if needed: Y___N___ If yes, please explain the reason (s):**

_____

_____

***METRO NORTH CARDIOVASCULAR ASSOCIATES, P.A.***
***Max Garoutte, M.D***
1003 NE Loop 410
San Antonio, Texas 78209
O: 210-654-6000
F: 210-654-6014

## Medicare Lifetime Signature on File

I _____, request that payment of authorized Medicare benefits be made on my behalf to ***Metro North Cardiovascular Associates, P.A.,*** for any services furnished by their physicians or associates. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____ _____
Signature of Patient Date

## Assignment of Benefits

ASSIGNMENT OF BENEFITS TO PHYSICIAN STATEMENT: I _____, hereby authorize assignment of payments directly to ***Metro North Cardiovascular Associates, P.A.,*** for the surgical and or medical benefits, if any, otherwise payable to me for the services described above. I understand that I am financially responsible for the charges not covered by this authorization or insurance. I hereby authorize ***Metro North Cardiovascular Associates, P.A.,*** to release any information relative to medical care received by me. If I have no insurance coverage, (payment arrangements MUST BE MADE PRIOR TO SERVICES RENDERED) my signature authorizes the releasing of the information to the insurer or agency shown. Patient/responsible party is responsible for the deductible, coinsurance, and non-covered services prior to services rendered. Coinsurance and deductibles are based on the charge determination of the beneficiary's carrier.

_____ _____
Signature of Patient, Parent, or Guardian Date

## Consent to Release of Information

I _____, hereby authorize ***Metro North Cardiovascular Associates, P.A.,*** to release any information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company(ies).

_____ _____
Signature of Patient, Parent, or Guardian Date

## Consent for Treatment

I _____, the patient, parent or legal guardian of said patient do hereby give my consent for medical examination, testing and treatment under the care of the practice as deemed necessary.

_____ _____
Signature of Patient, Parent, or Guardian Date

## HIPAA Compliance Acknowledgment

***Metro North Cardiovascular Associates, P.A.*** is committed to securing the privacy of your health information. Accordingly, we have copies of our practice's Notice of Privacy Practices available, if you wish to obtain a copy. You are not required to read this notice. However, we would like your acknowledgment that you have been notified that the practice has such a Notice of Privacy policies and that it is available to you.

_____ _____
Signature of Patient, Parent, or Guardian Date

***Metro North Cardiovascular Associates, P.A.***
***Max G. Garoutte, M.D.***

***Financial Policy***

It is the policy of this office to keep healthcare costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Your signature on this form indicates your understanding and agreement.

**Patient/Guardian Office Visit Responsibility:**

- Bring your Insurance and I.D. cards to every office visit and hand them to the person checking you in for your office visit when asked and **completely**fill out or update all forms handed to you.
- Be ready to provide payment in full. Copays and deductibles are due prior to services rendered.
- Bring an updated copy of all medications, vitamins and supplements to include the dose and frequency of the medication(s) you take. (Be sure to write or type this information at home with the bottles in front of you in order for the Provider to have a current list that is accurate of everything you take)
- Please allow up to 48-72 hours for any medication refills and give our office as much notice as possible to ensure you have enough medication to see you through. **Do not wait until the last day to ask for a refill.Keep all scheduled appointments with the Provider to ensure your medication refill will be approved.** We cannot refill medications for patients who do not follow-up with the Provider for a required face-to-face consultation.
- Our office calls patients the day prior to their scheduled appointment time. Please be sure to check your voicemail frequently in case we have contacted you to move an appointment and avoid you making an unnecessary trip into our office. Be sure to confirm your appointment with our office if we have failed to contact you in order to ensure your appointment time has not changed for any reason.
- Be sure to schedule appointments with plenty of time, in advance, for any scheduled surgeries or procedures in which you may be required to obtain a preoperative cardiac clearance. More than likely you will be required to have some type of cardiac testing prior to being cleared and must follow-up with the Provider in order to be cleared for such surgeries/procedures.

**Patient/Guardian Financial Responsibility:**

- ***Be prepared to pay your office visit in full prior to services rendered.***
- All past due balances are due prior to you being seen for your appointment.
- $25 fee for all D.O.T, FMLA, FAA and or Disability forms must be paid at the time they are dropped off
- $15 administrative fee for any **rushed requests** on letters, forms, medical records, or any other documents.
- $25 fee for a printout of any billing ledgers (i.e., account history, payment history, copies of billing statements, etc.) The fee is due prior to receiving the ledger. Please allow up to 24 hours for this to be made ready.
- $10 fee to fill out any health forms (i.e., wellness forms, clearance for full-duty, or return-to-work/school forms, health insurance form, sports or camp participation).
- $200 fee for all medical necessity letters written by the Provider.
- **$25 fee for all missed/no show** appointments or if the appointment is not canceled with a 24-hour notice. At the third incident, the Practice will send your PCP a letter of non-compliance or failure to follow-up and the Practice may choose to dismiss you as a patient.
- Monthly statements are mailed out for balances at the beginning of each month, and are due within 30 days of the statement date. If there are any disputes, concerns and or questions please contact the billing department immediately or in order to arrange payment arrangements and avoid your account being referred to collections.
- There is a fee for medical records you wish to hand-carry yourself to another physician and or wish to have for your personal file. The fee is $25 for pages 1-20, and $0.50 for each additional page thereafter.
- $50 fee for a C.D. of an Echocardiogram, Carotid Doppler, Venous Doppler, Abdominal Aortogram and Stress Echocardiogram you wish to have, prior to the C.D. being made.
- Services not covered by my health plan contract or provider not participating in my health plan.

I have read the above financial policy for Metro North Cardiovascular Associates, P.A., and I agree to the terms and conditions contained herein, assign all insurance benefits, if any, otherwise payable to me for services rendered directly to Metro North Cardiovascular Associates, P.A., I understand that I am financially responsible for ALL charges whether or not paid by the insurance. I hereby authorize, Metro North Cardiovascular Associates, P.A., to release all information necessary to secure payment of benefits.

| _____ | _____ | _____ |
|---|---|---|
| *Printed Patient/Guardian Name* | *Signature of Patient/Guardian* | *Date* |