PULSE
PHYSICIAN ORGANIZATION

Patient Information

Patient Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Social Security #: _____

Date of Birth: _____

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced

Driver's License #: _____

Email: _____

Primary Care Provider: _____

Patient Employer: _____

Work #: _____

Emergency Contact: _____

Phone: _____

Responsible Party: _____

Phone #: _____

Relationship to Patient: _____

Pharmacy Name: _____

Phone #: _____

Insurance Information

Card Holders Name: _____

Social Security Number: _____ Date of Birth: _____

Primary Insurance Name: _____ ID#/Group #_____

Secondary Insurance Name: _____ ID#/Group #_____

I hereby authorize Pulse Physician Organization to furnish to insurance carries concerning my illness and treatment and hereby assign all insurance benefits payable for services renders to my dependents or myself.

Signature: _____ **Date:** _____

Notice of Privacy Practices
Pulse Physician Origination

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THE INFOMRATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purposes of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, you health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health Care operations: Your health information may be used as necessary to support the day-to-day activities and management of Cypress Cardiology, P.A. For example, information on the services you received may be used to support budgeting, financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authoring a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us your decision to revoke your authorization.

Additional uses of information

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical conditions. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain right under federal privacy standards. These includes the following:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend and submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information and been disclosed.
- The right to receive a printed copy of this notice.

Pulse Physician Organization Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in the notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with most recent notice on any office visit. The revised policies and practices will be applied to all protected health information we obtain.

Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Miriam Rivera, Custodian of Records and Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints/Contact Person

If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to:

Privacy Official Administrator
Pulse Physician Organization
25450 Kukendahl Rd.
Tomball, TX 77375
(888) 785-7310

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing complaint.

Effective Date

This notice is effective on or after 5/10/2019

Notice of Privacy Practices, Acknowledgment of Receipt
Pulse Physician Organization reserves the right to modify the privacy practices outlined in the notice

Signature
I have received a copy of the Notice of Privacy Practices from Pulse Physician Organization

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or adult who is unable to sign this form)

_____
Relationship of Patient Representative of Patient

Authorization to Obtain or Release of Medical Records From Medical Providers

Patient Name: _____ Date of Birth: _____

Previous Names: _____ Social Security #: _____

I authorize Pulse Physician Organization ("the Practice") to obtain any and all medical records concerning my care from any physician, hospital, or other health care professional that has provided medical care to me in the past.

I also authorize the practice to release any and all medical records concerning my care to any physician, hospital or health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid, and any insurance company, third party administrator or Managed Care Company.

Please send (by mail or fax) the patient information to the selected address:

_____ Pulse Physician Organization – Huntsville (Dr. G. Aggarwala and J. Lawson, NP)
119 Medical Park Lane, Ste D, Huntsville, TX 77340
Fax: 936-994-9020

_____ Pulse Physician Organization – Katy (Drs. W. Pezzia, A. Sarkar, D. Wolf and E. Nyarko, NP)
714 S. Peek Rd., Katy TX 77450
Fax: 281-395-3959

_____ Pulse Physician Organization – Houston (Dr. J. Rogers, E. Ontiveros, PA, D. Reyes, NP, U. Ugwuegbulam, NP, C. Shipman-Wadley, NP)
2502 Canal Street, Houston, TX 77003
Fax: 936-994-9020

_____ Pulse Physician Organization – Cypress (Dr. G. Aggarwala and Esther Nyarko, NP)
21212 Northwest Fwy #405, Cypress, TX 77429
Fax: 281-894-0426

_____ Pulse Physician Organization – Trinity (Elizabeth Wilhite, NP and Cortney Simpson, NP)
303 South Robb Street, P. O.
Fax: 936-277-7102

_____ Pulse Physician Organization – Crockett (Dr. Relvert Coe and Cortney Simpson, MD)
200 Renaissance Way, Crockett, TX 75835
Fax: 936-243-6598

_____ Houston Family Clinic (Dr. Joanne Rogers)
4702 Emancipation Ave., Houston, TX 77004
Fax: 713-453-6967

_____ Pulse Physician Organization – Wound Care Center
116 Medical Park Lane, Ste C, Huntsville, TX 77340
Fax: 936-277-7102

_____ _____
Patient Signature Date

_____
Printed Name

PULSE
PHYSICIAN ORGANIZATION

Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff for the Practice to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of critical episode or if our are unable to give authorization due to the severity of your medical condition, the law stipulates that rules may be waived.

Please initial below:

_____ I do authorize the Practice to release any or all information concerning my medical care or finances to any individual EXCEPT as set forth above .

_____ I authorize the Practice to verbally release any or all information concerning my medical care or finances to the following individuals:

Name	Relationship to Patient	Contact Phone #
Name	Relationship to Patient	Contact Phone #

Print of Patient or Representative **Date**

Signature of Patient or Representative **Date**

PULSE
PHYSICIAN ORGANIZATION

Financial Policy

To reduce confusion and misunderstandings between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with the billing manger. We are dedicated to providing the best possible care and service and believe that your complete understanding of your financial responsibilities is an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at time of services. For your convenience we accept cash, check, VISA, MasterCard, Discover and AMEX.

Your health plan will only pay for services that it determines to be "reasonable and necessary". If your health plan determines that a particular service, although it would otherwise be covered, it is not "reasonable and necessary" under program standards, your plan will deny payment for this service. In the event that your plan determines a service "not covered", you will be responsible for the complete charge. Payment is due upon receipt of the statement form out office. As the patient, you are responsible for understanding your own benefits including deductibles that must be met and in-network versus out-of-network benefits.

If you are unable to keep your appointment time, please call our office as we require 24 hours advance notice for cancellations. "No Shows" and Same Day Cancellations" patients may be charged an additional fee.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient or Responsible Party if Patient is a Minor Date

Financial Policy

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangement is agreed upon. Our professional services are rendered to you, not the insurance company; therefore, payment for treatment is your responsibility. We have prepared this material to acquaint you with our policy. We encourage you to discuss any questions you have.

FINACIAL AGREEMENT

Initial	I have no insurance coverage. I understand that I am responsible for payment of serves rendered to departments or myself **at the time of services**.
Initial	I understand if I fail to pay amounts owed; the Practice has the right to secure an outside collection agency and/or attorney to collect the unpaid dept and to report the dept to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collect agency or attorney, including reasonable attorney fees.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Initial	I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made to Pulse Physician Organization for services rendered to my dependents or myself.
Initial	I understand I am responsible **at the time of service** for paying any required co-payments and/or deductibles. I understand that I am responsible for any amount not covered by my insurance.

MEDICARE/MEDIGAP

For Medicare Patient Only _____
Medicare Number

Initial	I authorize any holder of medical or other information about me to release to the Social Security Administration and Heath Care Finance Administration or its intermediaries or carries any information needed for this of related Medicare claim. I permit a copy of the authorization to be use in place of the original, and request payment of Medical insurance benefits either to myself of the party who accepts assignment. I understand it is mandatory to notify the healthcare provider od any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Medigap Authorization Statement _____
Policy Number

Initial	I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself prior to the party who accepts assignment.

NOTICE OF NON-CANCELLATION FEE

If you have an appointment scheduled in our office and you are not able to keep that appointment, you must give at least 24-hour notice of cancellation of your appointment during normal office hours. If you do not call the office 24 hours ahead of time, a non-cancellation fee of $20 will be Billed to you.

Initial	I understand that I am responsible for the $20 non-cancellation fee if you fail to cancel a scheduled appointment 24 hours in advance.

We accept cash, checks, and credit cards. There will be a $30 charge on all returned checks.

I have read and understand the payment policy and agree to abide by the said policy.

_____ _____
Patient/Parent/Guardian Date

I will be paying today by: _____ Check _____ Cash _____ Credit Card

Please present both your insurance card and your driver's license so we may make a copy for our records.

Venous Vascular Questionnaire

Patient Name: _____ **Age:** _____ **Date:** _____

Please read the below questions and circle "Yes or No" based on your personal history and experience. Once complete return to the attendee at the check-in desk.

1. Are you a current or previous smoker, have diabetes, high cholesterol or high blood pressure? Yes No

2. Do you or have you had an ulcer, wound or sore on your feet that is/was slow to heal? Yes No

3. Are you experiencing any of the following symptoms in your legs, ankles, or feet? Yes No Swelling, tender areas around the veins, or restless legs.

4. Have you or anyone in your family been diagnosed with varicose veins or venous reflux disease? Yes No

5. Have you previously attempted conservative treatment without success (E.G. exercise, weight loss, elevating legs, avoiding long periods of standing/sitting, compression stocking?) Yes No

----------For Staff Use Only----------

Venous Ref U/S: _____ DVT U/S: _____

Provider Name: _____ MD/AP

Signature: _____ MD/AP

Provider NPI: _____

Date of Service: _____

Patient Name: _____ **Age:** _____ **Date:** _____

LIST SURGERIES

Date:	**Reason**

LIST HOSPITALIZATIONS

Date:	**Reason**

Patient Name: _____ Age: _____ Date: _____

Please read the below questions and circle YES or NO based on your personal history and experience.

1. Have you had a seizure before?	YES	NO
2. Do you have a family history of seizures?	YES	NO
3. Have you ever had a brain injury?	YES	NO
4. Do you have a history of head trauma?	YES	NO
5. Any unexplained loss of consciousness?	YES	NO
6. History of staring off into space?	YES	NO
7. History of frequent headaches?	YES	NO
8. History of heart attack or stroke?	YES	NO

If you answered YES to any of the above questionnaire, please explain what occurred and how long it lasted:

Patient Name: _____ **Age:** _____ **Date:** _____

Please read the below questions and circle YES or NO based on your personal history and experience. Once completed, return to the attendee at the check-in desk.

1. Are you a current or previous smoker, have diabetes, high cholesterol or high blood pressure?	YES	NO
2. Do you have pain or cramping in the muscles of your buttock, thigh, or calf when you walk or climb stairs?	YES	NO
3. Does your pain stop when you stop walking?	YES	NO
4. Do you have leg pain while resting?	YES	NO
5. Do you have elg pain all the time?	YES	NO
6. Do you wake up at night due to burning and/or tingling in your feet that is relieved by dangling your feet over the bed or having to stand up?	YES	NO
7. Do you have you had an ulcer, wound or sore on your feet that is/was slow to heal?	YES	NO
8. Are you experiencing any of the following symptoms in your legs, ankles, or feet? Pain (Aching, camping feeling), heaviness, tiredness, burning or tingling sensation.	YES	NO
9. Have you previously had stents placed in your legs or heart OR have you previously had bypass surgery in your legs or heart?	YES	NO
10. Have you been diagnosed with coronary artery disease, carotid artery disease, kidney artery disease, or previously had a heart attack?	YES	NO
11. Have you ever been told you have poor pulses in your feet?	YES	NO
12. Have you previously attempted conservative treatment without success (e.g. exercise, weight loss, elevating legs, avoiding long periods or standing/sitting. compression stocking)?	YES	NO

----------For Staff Use Only----------

ABI: _____ LE Arterial U/S: _____

Provider Name: _____ MD/AP

Signature: _____ MD/AP

Provider NPI: _____

Date of Service: _____

PULSE
PHYSICIAN ORGANIZATION

SLEEP QUESTIONNAIRE

Patient Name: _____ Age: _____ Date: _____

Complete the below to the best of your knowledge. Once complete turn into the attendee at reception.

STOP-BANG screening

For each question below, circle the appropriate response. Once complete, total the score based on the number that is in the ( ) next to the selected answer.

Do you snore loudly?	No (0)	Yes (1)
Do you often feel tired, fatigued, or sleepy during the day?	No (0)	Yes (1)
Has anyone observed you stop breathing during sleep?	No (0)	Yes (1)
Do you have high blood pressure?	No (0)	Yes (1)
Body Mass Index: _____	<35 kg/m^2 (0)	>35 kg/m^2 (1)
Age: _____	<50 years (0)	>50 years (1)
Gender:	Female (0)	Male (1)
Neck Circumference: _____	<17 inches (0)	>17 inches (1)
Total Score (Add up all the ones (1's) for your total score)		

Epiworth Screening

For each question below mark an (X) in the field that corresponds best with your response to each situation. Once complete total the score and list it below.

How often do you doze off or fall asleep during the following situations? **0 = Never 1 = Rarely 2 = Frequently 3 = Always**				
	0	**1**	**2**	**3**
Sitting and reading				
Watching TV				
Sitting inactive in a public place (theatre, meeting, etc.)				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch with no alcohol consumption				
In a care, while stopped for a few minutes in traffic				
Total Score				

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MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Date:** _____

Reason for today's visit: _____

Allergies: _____

Patient history (Please circle YES or NO)

High blood pressure		YES	NO
Coronary artery disease		YES	NO
Diabetes		YES	NO
High Cholesterol		YES	NO
Congestive heart failure		YES	NO
Poor circulation		YES	NO
Pacemaker	If yes: date: _____	YES	NO
Heart Attack		YES	NO
Smoker	If yes: per day: _____	YES	NO
Cough		YES	NO
Shortness of Breath		YES	NO
Wheezing		YES	NO
Blood in Urine		YES	NO
Difficulty urinating		YES	NO
Nausea		YES	NO
Vomiting		YES	NO
Diarrhea		YES	NO
Constipation		YES	NO
Skin Rash		YES	NO
Swelling		YES	NO
Recent Weight loss		YES	NO
Fever		YES	NO

Family Member	Still Living (Circle)	Age	Health Conditions
Father	YES or NO		
Mother	YES or NO		
Sister (s) #_____	YES or NO		
Brother (s) #_____	YES or NO		