



Patient Registration Form

Today's Date: ___/___/___

Record Number: _____

PATIENT INFORMATION (Please use full legal name, no nicknames) (Mr.) (Mrs.) (Ms) (Dr)

Last Name _____ First Name _____ Middle Initial _____

Who referred you to our practice _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # (____) ____ - _____ Mobile/Pager # (____) ____ - _____ Other (____) ____ - _____ Social Security # ____ - ____ - _____

Date of Birth ___/___/___ Age ____ Sex ____ Marital Status: (Married) (Divorced) (Single) (Widowed) Drivers Lic # _____

Employer Name _____ Address _____

Work Phone # (____) ____ - _____ E-Mail Address _____

Emergency Contact Name _____ Relationship _____

Emergency Phone (____) ____ - _____ Pharmacy Name: _____ Phone # (____) ____ - _____

GUARANTOR INFORMATION: (List person responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient : (Self) (Spouse) (Parent) (Other) _____

If self and contact information is same as above, check here

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip Code _____

Date Of Birth ___/___/___ Age ____ Sex ____ Home Phone (____) ____ - _____ Work Phone # (____) ____ - _____

Employer Name _____ Address _____ City _____ ST _____ Zip _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards and driver's license)

Primary Insurance

Plan Name _____ Insured's Name _____

Insured's Social Security # ____ - ____ - _____ Insured's Date of Birth ___/___/___

Policy / ID # _____ Group # _____ Effective Date _____

Claims Address _____ Phone # (____) ____ - _____

Secondary Insurance

Plan Name _____ Insured's Name _____

Insured's Social Security # ____ - ____ - _____ Insured's Date of Birth ___/___/___

Policy / ID # _____ Group # _____ Effective Date _____

Claims Address _____ Phone # (____) ____ - _____

Mordecai N. Klein, MD, FACC
1600 Coit Road, Suite 304
Plano, TX 75075
P: 972-612-4730
F: 972-398-9229
www.harmonyheartgroup.com



Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE / PLAN BENEFITS:

I hereby authorize direct payment of insurance benefits to Harmony Heart Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand and agree that I am financially responsible for any co-pay or balance due that Harmony Heart Group is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Harmony Heart Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of Dr. Klein's Patient Information Privacy Policy. I hereby authorize Harmony Heart Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Harmony Heart Group representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Harmony Heart Group to that effect in writing.

AUTHORIZATION FOR VOICE MAIL with my consent (please initial one)

_____ (initials) Dr. M. Klein **may** call my home and leave a voice mail on my answering machine, speak to family members answering my phone, send mail or e-mail to my home in reference to any items that assist the practice in carrying out treatment, payment for operations, such as appointment reminders, billing information, insurance items, and any call pertaining to my clinical care, including laboratory results.

_____ (initials) I direct that Dr. M. Klein **may not** leave a message on my answering machine or speak to anyone in my household other than to myself.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Harmony Heart Group physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (please print): _____

Today's Date: ____/____/____

Name: _____ DOB ____/____/____ Account # _____ Sex: Male Female

What is the name of the doctor who referred you to us? _____ Name of your family M.D. _____

Why are you here to see a cardiologist (heart doctor)? _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY	DOCTOR TO FILL OUT
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Mark (X) on any HEART PROBLEMS or SYMPTOMS: Age: _____

HISTORY OF PRESENT ILLNESS:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Palpitations/irregular heart beat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Onset _____ |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Leg cramps when you walk | <input type="checkbox"/> Swollen legs | <input type="checkbox"/> Frequency _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Enlarged heart | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Location _____ |
| <input type="checkbox"/> Blue lips or fingernails | <input type="checkbox"/> Chest pains or pressure | <input type="checkbox"/> Heart murmur | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Abnormal rhythm (arrhythmias) | <input type="checkbox"/> Fainting | |

Mark (X) if you have ever had any of the following TESTS or PROCEDURES:
 (Indicate approximate year of the test or procedure)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Stress test _____ | <input type="checkbox"/> Coronary bypass surgery _____ | <input type="checkbox"/> Valve surgery _____ | <input type="checkbox"/> Quality _____ |
| <input type="checkbox"/> Electrocardiogram _____ | <input type="checkbox"/> Electrophysiology Study or Procedure _____ | | <input type="checkbox"/> Severity _____ |
| <input type="checkbox"/> Cardiac catheterization/Heart catheterization _____ | <input type="checkbox"/> Pacemaker or Defibrillator _____ | | <input type="checkbox"/> Timing _____ |
| <input type="checkbox"/> Coronary Angioplasty (balloon / atherectomy / stent) _____ | | | <input type="checkbox"/> Duration _____ |
| Please mark (X) if you have: | | | <input type="checkbox"/> Associations _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Overweight | <input type="checkbox"/> Aggravating _____ |
| <input type="checkbox"/> High cholesterol: Total _____ LDL _____ HDL _____ T ₃ _____ | | | <input type="checkbox"/> Alleviating _____ |
| <input type="checkbox"/> Ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit (number of packs per day) _____ | | | |
| <input type="checkbox"/> Presently smoking (number of packs per day) _____ | | | |

Has a close family member had:

- | | |
|--------------------------------|--|
| A heart attack? | <input type="checkbox"/> Yes <input type="checkbox"/> No (Mother – Father – Sibling) |
| Angina? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Bypass surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Carotid surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Surgery on their leg arteries? | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |

For women only: Could you be pregnant? Yes No

Have you passed menopause (change of life)? Yes No

At what age? _____ Do you take estrogen? _____

Are you being treated now or have you been treated for any illnesses?

Please list them:

1. _____ 3. _____
2. _____ 4. _____

Have you ever had any operations? Any injuries? (Please include date or year.)

1. _____ 3. _____
2. _____ 4. _____

Social History:

What is your Marital Status?

- | | | |
|---|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Single (never married) | <input type="checkbox"/> Widowed | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | |
| Spouse name _____ | Number of Children _____ | |

Occupation: _____

Major Hobby: _____

- Onset _____
- Frequency _____
- Location _____
- Quality _____
- Severity _____
- Timing _____
- Duration _____
- Associations _____
- Aggravating _____
- Alleviating _____

Cardiac Risk Factors?

Past Med Hx / Past Surgery

Social Hx / Family Hx

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

Please tell us about your medicines (names, dose or strength, how many times a day).
 Include over-the-counter medications and herbal medicines.
 Use doctor's column if necessary.

Name	Dose	Frequency
1. ASPIRIN YES / NO	81mg / 325mg	Enteric Coated YES / NO
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
Over-the-Counter Medications / Herbs		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Allergies:
 Do you have any drug allergies? Yes No (if yes, list them below)

Are you allergic to iodine, shrimp or shellfish? Yes No

Have you ever had a reaction to contrast dye? (e.g. Myelogram, kidney Series, CAT scan) Yes No

Have you had the following vaccinations?

- Influenza ("Flu Shot") Annually
- Pneumococcal ("Pneumonia") vaccine

Medicines:

Allergies:

Vaccinations:

Confidential - Protect Patient Privacy

Name: _____ DOB: _____ / _____ / _____ Date Seen: _____ / _____ / _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

REVIEW OF BODY SYSTEMS: Please mark (X) YES or NO to each SYMPTOM you have.

<u>Constitutional</u>	NO	YES	<u>Gastrointestinal</u>	NO	YES
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

<u>Eyes</u>	NO	YES	<u>Musculoskeletal</u>	NO	YES
See Spots	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			
Yearly Exams	<input type="checkbox"/>	<input type="checkbox"/>			

<u>Ears</u>	NO	YES	<u>Genitourinary</u>	NO	YES
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Burning with urination	<input type="checkbox"/>	<input type="checkbox"/>
			Difficulty starting or stopping urination	<input type="checkbox"/>	<input type="checkbox"/>

<u>Nose / Throat / Mouth</u>	NO	YES
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing Trouble	<input type="checkbox"/>	<input type="checkbox"/>

<u>Respiratory</u>	NO	YES	<u>Men</u>	NO	YES
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cough Blood	<input type="checkbox"/>	<input type="checkbox"/>			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			

<u>Hematologic</u>	NO	YES	<u>Neuropsychiatric</u>	NO	YES
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
			Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
			Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICAL EXAM

Height _____ Weight _____

BP: (Rt) _____ (Lt) _____
Pulse _____ Resp _____

PHYSICAL FINDINGS

HEENT:

PULM:

CARDIAC / PULSES:

ABD:

EXTREMITIES:

NEURO:

TESTING:

ASSESSMENT:

- 1.
- 2.
- 3.
- 4.

MEDICAL DECISION MAKING

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Dictated: _____
 Initials / Date

Mordecai N. Klein, MD, FACC
1600 Coit Road, Suite 304
Plano, TX 75075
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www.harmonyheartgroup.com



TODAY'S DATE: ___/___/___

RECORD NUMBER: _____

Medical Release of Information Form

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name: _____

I request and authorize

Mordecai N. Klein, MD, FACC
1600 Coit Road, Suite 304
Plano, TX 75075
P: 972-612-4730
F: 972-398-9229

Name of recipient: _____

Address: _____

City & State: _____ Zip Code: _____

Reason for release: _____

(initial appropriate line)

_____ **Health Care information relating to the following treatment condition or dates of treatment:**
This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.

_____ All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

_____ All Health Care information **excluding** information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

_____ I understand I have the right to revoke this authorization by providing a written request to do so to the above named physician or organization. I understand that the revocation will not apply to information that has already been released.

Signature of patient or authorized representative

Date

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Unless otherwise revoked this Authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

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HIPAA Notice of Privacy Practices

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.

Uses and Disclosures

Treatment. Your health information may be used by staff member or disclosed to other health care professionals for the purpose 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, your health plan may request and receive information on dates of service, 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 Harmony Heart Group. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who 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.

Research. Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing 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 of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you do not want us to contact you via the phone numbers you have already provided, and/or leave a voice message via those phone numbers, please check the following box(es):

_____ (Initials) Please do not contact me via the phone numbers provided to this practice.

_____ (Initials) Please do not leave a voice message via the phone numbers provided to this practice.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- 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 or submit corrections to your protected health information;
- The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- The right to receive a printed copy of this notice.

Practice 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 this 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 the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests 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 this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

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

HIPAA Privacy Officer
Mordecai N. Klein, MD, FACC
1600 Coit Road, Suite 304
Plano, TX 75075
P: 972-612-4730
F: 972-398-9229

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 may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

The office of Dr. Mordecai N. Klein reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (print)

Signature of Patient

Date of Signature

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

Relationship of Patient Representative to Patient

Please place in the patient's medical record.