HEARTFUL CARDIOLOGY

HEARTFUL CARDIOLOGY PLLC
2800 E Broad Street Suite 204
Mansfield, Texas, US - 76063-6411

Heartful Cardiology Policies

Privacy Practices

I understand that heartful cardiology has a policy that governs the disclosure of patient health information, as well as how patient may access their information. This policy is provided upon initiation of service or at patient's request. I may obtain a copy of my medical record at my own expense and upon my execution of an Authorization for Release of Medical Records Form.

Financial Agreement

I the undersigned person hereby acknowledge that at Heartful Cardiology PLLC , all payments are due at the time of service. Any other charges may be billed to me and all payments are due at the time of receipt.

Consent for Treatment

I (or my legal guardian/ parent) authorize Heartful Cardiology to provide medical care reasonable by today's standards. I also understand that if I am referred to a specialist, I will have to follow up to be continuously seen at this practice.

Personal Valuables & Accompanying Individuals

I understand that Heartful cardiology PLLC Is not responsible for the loss or damage to items. I also understand that any individual or family member accompanying me to Heartful Cardiology must obey all the posted rules. The clinic may remove myself/other individual from the premises and/or deny myself/ other individual services.

PATIENT SIGNATURE/ Legal Guardian * _____

Today's date * _____

Allergies

Allergies	Type	Severity	Reactions

HEARTFUL CARDIOLOGY

HEARTFUL CARDIOLOGY PLLC
2800 E Broad Street Suite204
Mansfield. Texas. US - 76063-6411

Medications & Supplements

Medications

Medication Name	Intake Details

HEARTFUL CARDIOLOGY PLLC
2800 E Broad Street Suite 204
Mansfield, Texas, US - 76063-6411

Additional Information

What is the name of your Primary Care Physician? *

What is the address and telephone of the Dr.'s office? *

What is the name, address and telephone number of your preferred Pharmacy? *

Do you have a previous Cardiologist? If so, what is their name, and phone number? *

HEARTFUL CARDIOLOGY PLLC
2800 E Broad Street Suite 204
Mansfield, Texas, US - 76063-6411

* Informed Consent and Release

Informed Consent and Release

CONSENT TO NATUROPATHIC CARE

If I am ever scheduled for a Nuclear/Pharmacological Stress Test, I understand that I am to call **48 hours** prior to my appointment time for any cancellations. If I **"No Show"** my appointment, or if I **don't cancel 48 hours before my appointment**, I understand that I will be charged a **$200 fee**. The only instance in which this fee will be waived is hospital admission. In instances where we are closed, please leave on office voicemail.

If I am ever scheduled for an **Echo or Doppler,** I understand that I am to call **48 hours prior** to my appointment time for any cancellations or reschedules. If I **"No Show"** my appointment, or if I **don't cancel/reschedule 48 hours before my appointment**, I understand that I will be charged a **$50 fee**. The only instance in which this fee will be waived is hospital admission. In instances where we are closed, please leave on office voicemail.

If I am ever scheduled for a **Stress-Echo,** I understand that I am to call **48 hours prior** to my appointment time for any cancellations or reschedules. If I **"No Show"** my appointment, or if I **don't cancel/reschedule 48 hours before my appointment**, I understand that I will be charged a **$100 fee**. The only instance in which this fee will be waived is hospital admission. In instances where we are closed, please leave on office voicemail.

PATIENT SIGNATURE* _____

TODAY'S DATE* _____

HEARTFUL CARDIOLOGY PLLC
2800 E Broad Street Suite 204
Mansfield, Texas, US - 76063-6411

Heartful Cardiology Release Medical Records

Authorization to Release Medical Records

This document must be written, dated and signed by the patient or a person legally authorized to do so.

Patient Legal Name: *

Date of Birth: *

To release a copy of my medical information specified below to:
Heartful Cardiology
2800 E Broad street STE 204
Mansfield, TX 76063

Tel: 817-752-5242
Fax: 817-752-5232

I specifically authorize the release of the following medical records and person health information, if such records exist: *

- ☐ Entire medical record
- ☐ Clinician office chart notes
- ☐ Records needed for continuity of care
- ☐ Laboratory reports
- ☐ Diagnostic imaging reports
- ☐ Emergency and Urgent care records
- ☐ Pathology reports
- ☐ Dental records

PATIENT SIGNATURE or legal representative *

Date *

HEARTFUL CARDIOLOGY PLLC
2800 E Broad Street Suite 204
Mansfield, Texas, US - 76063-6411

TeleHealth Informed Consent - Optional

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to heartful cardiology PLLC to provide services to me via telehealth.

INITIAL: _____

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. Heartful cardiology PLLC does bill insurance and all payments are paid at the time of service.

You will have access to your medical records in accordance to HIPPA.
I understand that I will be responsible for any service rendered by Heartful Cardiology PLLC.

INITIAL: _____

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care of treatment. I may revoke my consent orally or in writing at any time by contacting Heartful Cardiology PLLC. As long as this consent is in force Heartful Cardiology PLLC can provide health care services to me via telehealth without the need for me to sign another consent form.

INITIAL: _____

PATIENT SIGNATURE _____

Date Document Signed: _____