

Acknowledgement of Receipt of Privacy Practices (to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

I wish to give the following individuals access to my health information: _____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

Red Oak Cardiovascular, P.A.

Notice Of Privacy Practices

Effective April 14, 2003

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.

Our Promise To You, Our Patients

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

INTRODUCTION

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the offices of Red Oak Cardiovascular Center, P.A., we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit Red Oak Cardiovascular Center, P.A., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- ❖ Basis for planning your care and treatment.
- ❖ Means of communication among the many health professionals who contribute to your care.
- ❖ Legal document describing the care you received.
- ❖ Means by which you or a third-party payer can verify that services billed were actually provided.
- ❖ Tool in educating health professionals.
- ❖ Source of data for medical research.
- ❖ Source of information for public health officials charged to improve the health of the state and nation.
- ❖ Source of data for our planning and marketing.
- ❖ Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Red Oak Cardiovascular Center, P.A., the information belongs to you. You have the right to:

- ❖ Obtain a paper copy of this notice of privacy policies upon request.
- ❖ Inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law).
- ❖ Amend your health record as provided by 45 CFR 164.526.
- ❖ Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528.
- ❖ Request confidential communications of your health information as provided by CFR 164.522(b).
- ❖ Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522(a) (however, we are not required by law to agree to a requested restriction).

Our Responsibilities

Our practice is required to:

- ❖ Maintain the privacy of your health information.
- ❖ Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- ❖ Abide by the terms of this notice.
- ❖ Notify you if we are unable to agree to a requested restriction.
- ❖ Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosure For Treatment, Payment, And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken.

For More Information Or To Report A Problem

If you have questions and would like additional information, you may contact our practice at 281-893-8640.

If you believe your privacy rights have been violated, you can either file a complaint with our Medical Director or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Texas is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

Examples Of Disclosures For Treatment, Payment And Health Operations

We will use your health information for treatment.

We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among health care professionals involved in your care.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.

We may disclose your information so that we can collect or make payment for the health care services you receive.

For example:

If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.

We will use your health information for regular health operations.

We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions.

For example:

Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce healthcare costs.

❖ **Appointment Reminders**

We may disclose medical information to provide appointment reminders (e.g., contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).

❖ **Decedents**

Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.

❖ **Workers Compensation**

We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

❖ **Public Health**

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

❖ **Research**

We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review/Privacy Board, who has reviewed the research proposal.

❖ **Organ Procurement Organizations**

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation and transplant.

❖ **As Required By Law**

We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process, or complying with health oversight activities, such as audits, investigations, and inspections, necessary to ensure compliance with government regulations and civil rights laws.

❖ **Specialized Government Functions**

We may disclose health information for military and veterans affairs or national security and intelligence activities.

❖ **Business Associates**

There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

❖ **Practice Marketing**

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (for example, to notify you of any new tests or services we may be offering).

❖ **Food And Drug Administration (FDA)**

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

❖ **Personal Representative**

We may use or disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care).

❖ **To Avert A Serious Threat To Health/Safety**

We may disclose your information when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

❖ **Communication With Family**

Unless you object, health professionals, using their best judgment, may disclose to a family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care. We may notify these individuals of your location and general condition.

❖ **Disaster Relief**

Unless you object, we may disclose health information about you to an organization assisting in a disaster relief effort.

For all *non-routine* operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.

Patient HIPPA Consent Form

1. **Sharing information for the purpose of treatment:** I understand that you may share my information with members of my treatment team, both within Red Oak Cardiovascular Center as well as with providers whom administer care outside of this center, in order to provide me information on wellness programs as well as educational programs specified by my insurance plan.
2. **Sharing information for the purpose of payment:** I give permission for Red Oak Cardiovascular Center to share my information with my insurance company, governmental entities (such as Medicaid or Medicare, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives, data warehouses and billing companies.
3. **Sharing information for purpose of operation:** I give my permission for Red Oak Cardiovascular Center to share all information needed for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.
4. **I authorize that your office may contact me in the following matter:** (please check all that apply)

Home Telephone:

- OK to leave a message in detail on the answering machine
- OK to leave a message with a callback number only
- OK to leave a message with a family member

Specify who: _____

Work Telephone:

- OK to leave a message in detail on the answering machine
- OK to leave a message with a callback number only
- OK to leave a message with co-worker

Specify who: _____

Cellular Telephone:

- OK to leave a voicemail message in detail
- OK to leave a message with callback number only

My consent is freely given. I understand that I may revoke this consent at any time in writing; but understand any disclosures given in reliance on this prior consent will be permissible.

Print Patients name

Date

Patient's signature

Guardians Name

Witness signature

Date



Comprehensive Outpatient Services

17400 Red Oak Drive • Houston, TX 77090 • 281/893-8640

Juan R. Amell, M.D., F.A.C.C. • Metram J. Rao, M.D., F.A.C.C.
Gustavo A. Grieco, M.D., F.A.C.C. • Amilcar Avendaño, M.D., F.A.C.C.

Visit our Web Site at: www.redoak.com

We are committed to providing you with the best possible care. If you have medical insurance, we will gladly assist you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our policy.

Payments for services are due at time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover, or Insurance Assignment. We will gladly discuss your proposed treatment and answer any question relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.
2. If your insurance company requires referrals, vouchers or authorizations, YOU will present these to the receptionist immediately. Failure to do so will make you responsible for full payment once services are rendered.
3. Our fees are generally considered to fall within an acceptable range by most companies (Usual, Customary, and Reasonable). U.C.R. charges are normally covered up to the maximum allowance determined by each carrier, as stated in your individual policy. This statement does not apply to companies who reimburse on an arbitrary fee "schedule" (predetermined), which bears no relationship to the U.C.R. in this area.
4. Some insurance companies arbitrarily select certain services that may not be covered by your plan.
5. We do accept Medicare, however, if you do not hold a supplemental plan, the remaining 20% balance is your responsibility.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I authorize and assign payment of any medical benefits to Red Oak Cardiovascular Center, P.A.

I authorize Red Oak Cardiovascular Center, P.A., to disclose and release medical information to my insurance company(s) for the purpose of securing payment of insurance benefits. I have been informed that my records may contain information, which is protected by State and Federal Confidentiality laws. This includes information pertaining to hospitalization and treatment for drug or alcohol abuse, psychiatric treatment, and HIV test results. This consent will remain in effect only until the insurance claim has been settled and may be revoked prior to that time, except to the extent that action has already been taken in reliance upon it.

I authorize and give consent to my doctor and whomever he/she designates to perform upon myself, diagnostic tests to determine the condition of my heart and/or blood vessels. I understand any invasive procedures will require a separate informed consent form.

Signature

(Relationship if minor)

Date

Patient HIPPA Consent Form

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2. **Sharing information for the purpose of payment:** I give permission for Red Oak Cardiovascular Center to share my information with my insurance company, governmental entities (such as Medicaid or Medicare, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives, data warehouses and billing companies.
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Print Patients name

Date

Patient's signature

Guardians Name

Witness signature

Date



Comprehensive Outpatient Services

17400 Red Oak Drive • Houston, TX 77090 • 281/893-8640

Juan R. Arnell, M.D., F.A.C.C. • Metram J. Rao, M.D., F.A.C.C.
Gustavo A. Grleco, M.D., F.A.C.C. • Amilcar Avendaño, M.D., F.A.C.C.

Visit our Web Site at: www.redoak.com

ATTENTION ALL PATIENTS

All patients who are on an HMO or POS (Point of Service) Insurance Plan that requires a referral must have the **Referral and Insurance Card** at the time of the visit. If you do not have the referral and insurance card, you must reschedule your appointment or you must pay for your visit at the time of service. Referrals are the patient's responsibility, not our office. No calls will be made to verify benefits on the day of testing.

The patient is responsible for all balances if the insurance information given to Red Oak Cardiovascular Center is **incorrect or incomplete**. If insurance information is given after claims are filed and your insurance carrier determines **claims are past filing deadline**, patient is responsible for remaining balance on account.

PLEASE NOTE:

**DUE TO HEALTH AND SAFETY ISSUES,
CHILDREN ARE NOT ALLOWED IN WORK,
TESTING OR CLINICAL AREAS.**

THANK YOU FOR YOUR COOPERATION



May 11, 2009 3:19 PM
 Dr. Gustavo A. Grieco, M.D., F.A.C.C.
 Dr. Amílcar Avendaño, M.D., F.A.C.C.
 Dr. Vinay Rao Julapalli, M.D.

No. 6365 P. 9

Comprehensive Outpatient Services

17400 Red Oak Dr. Houston, TX 77090-1246
 Office: 281-893-8640
 Web Site: <http://www.redoak.com> • E-Mail: redoak@redoak.com

920 Medical Plaza Dr., Suite 495
 The Woodlands, TX 77380
 Office: 281-363-3434

MEDICAL HISTORY

Date: _____

Patient Name: _____

D.O.B.: _____ Sex: Male Female Height: _____ Weight: _____

Referring Physician: _____

Referred by (other sources): _____

Reason for seeing Dr. Amell/Dr. Rao/Dr. Grieco/Dr. Avendaño/ Dr. Vinay Rao Julapalli _____

Do you have any Chest Pains/Chest Discomfort YES NO
 (If YES, please describe in your own words) Severity Scale: (Least Severe) 1 2 3 4 5 6 7 8 9 10 (Most Severe)

- Do you have any of the following symptoms? YES NO
- Shortness of Breath
 - Ankle Swelling/Fluid Retention
 - Need to Urinate After Bedtime
 - Sleep on More Than One Pillow
 - Palpitations/Irregular Heart Beat
 - Heartburn/Indigestion
 - Excessive Perspiration
 - Dizziness
 - Headaches
 - Vision Changes
 - Coughing
 - Fainting Spells
 - Weakness or Numbness to Arms or Legs
 - Aching in Legs When Walking
 - Difficulty Sleeping
 - Anxiety
 - Depression

- Do you have any history of the following conditions? YES NO
- Angina Pectoris (Chest Pain)
 - High Blood Pressure
 - Diabetes
 - Arteriosclerosis (Hardening of the Arteries)
 - Elevated Cholesterol
 - Lung Disease (Emphysema)
 - Anemia
 - Arthritis
 - Back Pain
 - Gout

- Have you ever had any of the following conditions? YES NO
- Heart Attack
 - Abnormal EKG
 - Chest Injury
 - (Please Describe): _____
 - Congestive Heart Failure
 - Heart Murmur
 - Rheumatic Fever
 - Stroke
 - Seizure Disorder
 - Head Injury
 - Pneumonia
 - Abnormal Chest X-Ray
 - Hiatal Hernia
 - Ulcers
 - Bleeding in Stomach
 - Abdominal Aneurysm
 - Gallbladder Stone(s)
 - Diarrhea
 - Constipation
 - Kidney Stone
 - Kidney Infection
 - Blood Sugar Abnormality
 - Thyroid Disorder
 - Hepatitis
 - Tuberculosis
 - Cancer
 - Breast Nodule
 - Bleeding Tendency
 - Easy Bruising
 - Low Back Problems
 - Bone Fractures

HOSPITAL ADMISSIONS INCLUDING SURGERIES:

Date:	Hospital:	Physician:	Diagnosis:	Surgeries:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PLEASE LIST ALL MEDICATIONS (Prescribed and Over the Counter Medicines):

Medicine	Dosage	Frequency Taken	Date Started	Date Stopped:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergies: Medicine(s): _____
 Food: _____
 Environmental: _____
 Other: _____

PERSONAL HABITS:

Smoking: Did You Ever Smoke? YES NO How Many Packs per Day? _____
 How Many Years Did You Smoke? _____ Do You Smoke Now? YES NO
 When Did You Stop Smoking? _____

Alcohol Use: Current Amount of Wine, Liquor or Beer per Week? _____ Any History of Alcohol Use? YES NO

Drug Use: Any History of Illegal Drug Use/Abuse? YES NO
 If YES, Please Explain: _____

Exercise: Are You Currently on an Exercise Program? YES NO Number of Times per Week _____

Cholesterol: Have You Ever Had Your Cholesterol Checked? YES NO If So, When? _____
 What Were Your Levels? CHOL: _____ HDL: _____
 TRIG: _____ LDL: _____

Diet Restrictions: Salt Sugar Cholesterol/Low Fat Fluid Restrictions Caffeine
 Other: _____

Stress: Occupation: _____
 Marital Status: Married Single Widow Divorced
 Recent Major Life Changes: _____

Please Check the Following Tests Which have been Done Within the Past Year:

Female: Regular Physical Exams Pap Smear (Positive Negative) Breast Exam
 Mammogram Colon Exam

Male: Regular Physical Exams Prostate Exam Colon Exam

Do Members of Your Family Know CPR? YES NO Do You Know CPR? YES NO

FAMILY HISTORY:

Have You or Your Family Members Had Any of the Following Diseases (If YES, Please List Who They Are)?

Heart Disease: _____
 Diabetes: _____
 Hypertension: _____
 Cancer: _____
 Stroke: _____
 Emphysema: _____

ADDENDUM TO HISTORY & PHYSICAL

Date: _____

PSYCHOSOCIAL ASSESSMENT — Please check the following as applies:

- Anxiety
- Depression
- Stress

RECENT LIFE CHANGES:

- Job change in last year
- Divorce in past year
- Death of parent in last year
- Job lost
- Separation
- Death of spouse in past year
- Unemployed
- Loss of financial security
- Death of child in past year
- Retired
- Hospitalization in past year
- Child moving away
- Moved in last year
- Injury/sickness in past year
- Birth of child / grandchild
- Loss of hope
- Feelings of despair
- Parent comes to live

SOCIO-ECONOMIC STATUS:

- Lives alone
- Lives with family
- Lives with spouse
- Extended-Care facility
- Child living at home

Living Will	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organ Donation	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you or any of your family members been a victim of physical, sexual, verbal or mental abuse? Yes No

If Yes, please explain briefly: _____

Have you or any member of your family been in treatment for alcohol, drug, physical, psychological abuse? Yes No

If Yes, please explain briefly: _____

Development/Educational/Learning Deficits:

- Attention Deficit Disorder
- Hard of hearing
- Blind
- Deaf
- Dementia
- CVA

COGNITIVE/PERCEPTION

Method of Learning:

- Visual
- Audio
- Demonstration
- Reading

Communication Abilities (appropriate for developmental age):

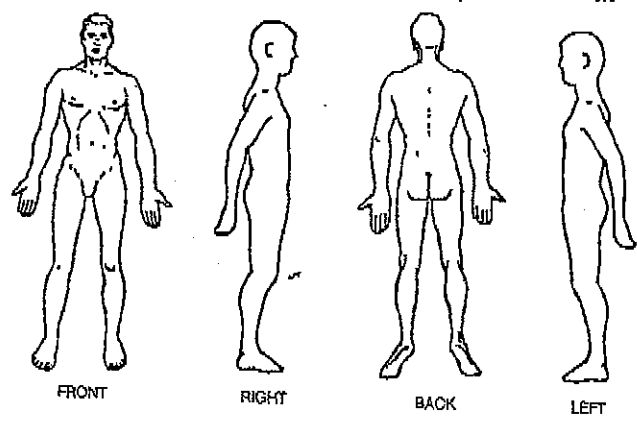
- Can speak
- Can write
- Understands writing
- Understands gestures

Understands English If not, state language spoken: _____

PLEASE MARK AREAS OF SCARRING, FRACTURES, SKIN TEARS, LACERATIONS, BRUISING:

SKIN:

- Intact
- Poor turgor
- Itching
- Rash
- Lesion
- Bruise
- Decubitus
- Scar
- Warm
- Cool
- Dry
- Moist
- Pale
- Pink
- Cyanotic
- Ashen
- Jaundiced



SKIN ASSESSMENT CODE:

- R = Rash
- S = Scar
- D = Decubitus
- L = Laceration
- T = Tattoo
- AM = Amputation
- AB = Abrasion

Date: _____

PHYSICAL EXAMINATION

PLEASE INDICATE IF PHYSICAL ASSESSMENT IS POSITIVE OR NEGATIVE USING A (+) OR (-) SIGN RESPECTIVELY.

VITAL SIGNS: BP (L): _____ BP (R): _____ HR: _____ RR: _____
Temp: _____ Wt: _____ Ht: _____ O₂ Sat: _____ %

HEENT: Unremarkable.

NECK: Supple, No Jugular Venous Distension, Mass, or Carotid Bruit.

LUNGS: Clinically Clear.

HEART: RRR, S1 & S2 Normal, No Murmur, Gallop or Rub.

ABDOMEN: Soft, Non-Tender, No Organomegaly or Mass. BS Normal.

EXTREMITIES/PERIPHERAL PULSES: No Pedal Edema. 2+ Equal Bilaterally.

CNS: Grossly Intact.

EKG:

ASSESSMENT:

- | | |
|----|----|
| 1) | 3) |
| 2) | 4) |

PLAN:

- | | |
|----|----|
| 1) | 3) |
| 2) | 4) |

COMMENTS: _____

RTC: _____ M.D. / _____ R.N.

(DOCTOR USE ONLY)

(DOCTOR USE ONLY)