



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 Avendano, M.D., F.A.C.C.
Vinay R. Julapalli, M. D.

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



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 Avendano, M.D., F.A.C.C.
Vinay R. Julapalli, M. D.

We welcome you to our center. To best serve you and meet your needs, it is necessary for us to have the most current information.

NEW HOSPITAL PATIENT UPDATE

TODAY'S DATE: _____ **REFERRING PHYSICIAN:** _____

PATENT INFORMATION:
NAME: (LAST) _____ (FIRST) _____ (MI) _____

ADDRESS
STREET NUMBER _____ CITY _____ STATE _____ ZIP CODE _____
HOME PHONE: () _____ WORK PHONE: () _____ E-MAIL ADDRESS: _____

AGE: _____ DATE OF BIRTH : _____ SOCIAL SECURITY # _____

DRIVERS LICENSE # _____ SEX: MALE _____ FEMALE _____
MARITAL STATUS: _____ MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____
EMPLOYED : _____ YES _____ NO _____ IF YES LIST EMPLOYER NAME: _____

OCCUPATION : _____ EMPLOYER ADDRESS: _____

SPOUSES NAME : _____ SPOUSES DATE OF BIRTH: _____
PARENTS NAME (IF PATIENT IS A MINOR): _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

FAMILY MEMBERS NAME : _____ FRIEND'S NAME: _____
PATIENT'S NAME: _____ YELLOW PAGES _____ INSURANCE PLAN _____
ANOTHER DOCTOR: _____ OTHER: _____
(PLEASE SPECIFY SOURCE)

EMERGENCY INFORMATION

IN CASE OF AN EMERGENCY PLEASE LIST THE NAME OF A LOCAL RELATIVE AND/OR FRIEND TO NOTIFY NOT LIVING WITH YOU:
1. NAME: _____ RELATIONSHIP _____ PHONE#: _____
2. NAME: _____ RELATIONSHIP _____ PHONE#: _____

INSURANCE INFORMATION

TYPE OF PLAN: _____ MEDICARE _____ HMO _____ PPO _____ INDEMNITY _____ SELF PAY _____
PRIMARY INSURANCE: _____ PHONE# FOR BENEFITS: _____
NAME OF INS COMPANY _____
INSURED EMPLOYEE NAME: _____ POLICY HOLDER NAME: _____
INSURED BIRTH DATE: _____ IF PLAN IS AN HMO LIST PCP NAME: _____
I.D. NUMBER : _____ GROUP NUMBER : _____

SECONDARY INSURANCE: _____ PHONE # FOR BENEFITS: _____
INSURED EMPLOYEE NAME: _____ POLICY HOLDER NAME: _____
INSURED BIRTH DATE: _____ IF PLAN IS AN HMO LIST PCP NAME : _____
I.D. NUMBER : _____ GROUP NUMBER : _____



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 Avendano, M.D., F.A.C.C.
Vinay R. Julapalli, M. D.

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