James M. Wilson, M.D. - Medical Information
Email to wilson@houstonmds.org (fax to 713-790-1605)

PATIENT INFORMATION

Last name:	First:	D.O.B:	
SSN:		Age:	Gender: M F
Home Phone #:	Cell Phone #:	Work Phone #:	
May we leave message? Y / N	Where should we call? Home Cell Work		
Can we email? Yes No	Email:		

Street address:
City: State: TX ZIP:

Occupation:

Primary Physician: Ph:

Best time to reach you? Time: Day of the week:

Pharmacy:
Telephone Number:

INSURANCE INFORMATION – We will need a photo or copy of your insurance card emailed to

Primary Ins.:
ID#: Group#:

Policy Holder Name & DOB:	Employer:	Employer phone #:

Secondary Ins.:
ID#: Group#:

Ins. Phone #: Ins. Address:

Policy Holder Name & DOB:	Employer:	Employer address:	Employer phone #:
			( )

IN CASE OF EMERGENCY

Name: Relationship: Home phone #:( ) Work phone #:( )

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Parent if Minor Date

I attest that this information is true, accurate and complete to the best of my knowledge

Authorization for Use and Disclosure of Protected Health Information (PHI)

James M. Wilson, M.D.
Phone (832)336-1530 Fax 713-790-1605

Last name: First: Telephone #:	Date of Birth:	SSN#:

Street address:	City:	State:	ZIP Code:	

I authorize	(Patient's physician) or Facility

to disclose my medical record information and / or protected health information for the purpose of medical care to:

James M. Wilson
6560 Fannin, #1836
Houston, Texas 77030
Email wilson@houstonmds.org Phone (832)336-1530 Fax 713-790-1605

I authorize James M. Wilson, M.D. and associates to disclose my medical record information and / or protected health information to:

(Identify your insurance Company):

Type of access requested:

1. Letter of Medical Necessity
2. Progress Notes
3. Lab Work
4. Medication Record
5. Operative Report

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, or psychiatric information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization maybe subject to re-disclosure by the recipient and no longer protected. I understand that the condition for release is not based on payment for treatment and care, enrollment or eligibility or whether I sign the authorization.
Fees/charges will comply with all laws and regulations applicable to release of information.
I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Parent if Minor Date

James M. Wilson, M.D., FACC

CARDIOVASCULAR PATIENT MEDICAL HISTORY

Name:_____

Main Problem:

Allergy or Intolerance:_____

Latex ☐ Iodine/x-ray dye ☐

Risk/Prior History

Event/Procedure	Date(s)
Heart Attack	
Atrial Fibrillation/Ablation	
Stent	
Bypass/Vascular repair	
Valve repair/replacement	

Pacemaker ☐ ICD ☐

Non-Cardiac Illness	Date(s)

Non-Cardiac Surgery	Date(s)

Please provide most recent cardiac test date

Stress test _____ Echocardiogram _____ Angiogram _____

Smoking ☐ Years _____

Diabetes ☐ High Cholesterol ☐ High blood pressure ☐

Family History of Heart disease ☐ Kidney Disease ☐

Blood Clots ☐ Sleep Disorder/Apnea ☐

Peripheral Vascular Disease ☐

History Alcohol consumption: ☐ Amount/D _____

Stroke/TIA ☐ Heart Murmur ☐ Thyroid disease ☐

Blood Transfusions ☐ Cancer ☐ Hepatitis ☐

Marital Status M ☐S ☐D ☐ReM ☐ Children ____

Employed ☐Retired ☐Disabled ☐ Type of Work _____

Activity Level

☐I can climb 2 flights of stairs without resting

☐I can sweep or vacuum a room without stopping

☐I can make a bed without stopping

☐I can shower and groom for the day without stopping

☐I can do none of the above.

Anything I might have missed?

☐Weight loss ☐Fever Sweating at night ☐Loss of appetite

Neurologic

☐numbness/tingling ☐unexplained headache ☐weakness

☐difficulty walking ☐tremor ☐difficulty with memory ☐muscle weakness

Kidney/Bladder

☐urinary frequency/burning ☐blood in urine ☐nighttime urination

Eye, Ear, Nose & Throat

☐vision problems ☐hearing loss ☐vertigo ☐ringing

☐sinus problems ☐difficulty swallowing

Musculoskeletal

☐joint pain/swelling ☐swelling of feet/ankles

Stomach/Intestine

☐heartburn/indigestion ☐Nausea or pain with eating ☐diarrhea

☐blood in stools ☐abdominal discomfort

Lungs

☐cough ☐shortness of breath ☐coughing up blood ☐wheezing

Blood/Lymph Glands

☐ bruising ☐bleeding

Psychiatric

☐anxiety ☐depression

Endocrine

☐warm or cold unlike others ☐flushing ☐change in skin color ☐loss of hair

Medicine:	Dose/Frequency:

James M. Wilson, MD

Please read this and sign below indicating that you understand the guidelines.

APPOINTMENT

If you find that you are unable to keep your appointment, please call to cancel 24 hours in advance so that a time will be available for other patients.

INSURANCE AND FEES

I agree to pay for any and all medical services I receive from the doctor/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, plan does not pay for preventive medicine visits or my failure to secure a referral from my primary care physician) I will pay for the visit upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

ACCOUNT BALANCES AND RETURNED BANK ITEMS

- Our office staff will always be glad to discuss fees with you. Should you have financial problems that result in the delay of payment, we will not know unless you tell us. We will make every effort to work out an acceptable payment plan to enable you to take care of your obligation.
- Patient account balances that exceed 60 days without payment will be turned over to our collection agency.
- We accept Cash, Check, Visa, MasterCard, or Money orders.
- If your check is returned from the bank, we will add the “returned fee” to your account in the amount of $30.00.

I have read, understand, and agree to all of the above statements. I understand the charges not covered by my insurance, as well as applicable co-payment and deductible are my responsibility.

Signature Date

James M. Wilson

Consent for Email Communication

We have established an email address for some forms of communication. Email is not appropriate for use in an emergency or for private/diagnosis related information. The turnaround time for routine patient communications is 24 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, call your primary physician or the main office number**. Please include your name, date of birth and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails.

We are dedicated to keeping your medical record information confidential. Due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control. I understand and agree to the above email policy. By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

Signature Date:

James M. Wilson, M.D.

PERSONS WHO ARE AUTHORIZED TO RECEIVE INFORMATION:
HEALTH INFORMATION OUR OFFICE COLLECTS OR RECEIVES ABOUT YOU MAY BE DISCLOSED TO THE FOLLOWING PERSONS:

NAME: _____RELATIONSHIP:_____

NAME: _____RELATIONSHIP: _____

USE AND DISCLOSURE OF INFORMATION:

_____ **PLEASE INITIAL** I AUTHORIZE THE PERSON(S) LISTED ABOVE TO RECEIVE ALL HEALTH INFORMATION ABOUT APPOINTMENTS, TREATMENT AND/OR OTHER INFORMATION PERTINENT TO MY HEALTHCARE AND /OR PAYMENT FOR MY HEALTHCARE.

-- OR –

_____ **PLEASE INITIAL** I DO NOT AUTHORIZE ANY INFORMATION TO BE DISCLOSED TO ANY OTHER PARTIES EXCEPT TO ME AS THE PATIENT.

YOU MAY REVOKE OR TERMINATE THIS AUTHORIZATION BY SUBMITTING A WRITTEN REVOCATION TO OUR OFFICE TO ATTENTION OF THE PRIVACY OFFICIAL OR OTHER AUTHORIZED REPRESENTATIVE. HOVEVER, YOUR DECISION TO REVOKE THE AUTHORIZATION WILL NOT BE IN EFFECT OR UNDO ANY USE OF DISCLOSURE OF INFORMATION THAT OCCURRED BEFORE YOU NOTFIED US OF YOUR DECISION.

COMMENTS:_____
_____
_____

_____ PLEASE INITIAL I have received the information entitled "Notice of Privacy Policies and Practices"

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

NOTICE OF PRIVACY POLICIES AND PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice 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, 2016 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit our office, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- **Basis for planning your care and treatment**
- **Means of communication with other health professionals involved in your care**
- **Legal document outlining and describing the care you received**
- **A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided**
- **A tool that we can reference to ensure the highest quality of care and patient satisfaction**

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR 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; must be in writing
- 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 a printed copy of this notice

OUR RESPONSIBILITIES

Our office is required to:

- Maintain the privacy of your health information
- We are required by law to 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 and acknowledge revisions with notifications
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/locations

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. Any updates will be posted in our office. We will not use or disclose your health information without your authorization, except as described in this notice.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members 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 us.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of NHFP. For example: information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services to us. These “associates” require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these “business associates” might be a collection agency, answering service and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment (ex: emergency situations) when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. We will ask patients 18 years and older to sign a consent to release information to anyone other than themselves.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminders. This practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail or a brief, non-specific message may be left on your answering machine / voicemail.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written 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.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or privacy practices please contact us.

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D. C. 20201