

**HOUSTON CARDIAC SURGERY ASSOCIATES, LLP  
HOUSTON VEIN INSTITUTE**

**PATIENT INFORMATION**

PATIENT  
NAME \_\_\_\_\_

First

Middle

Last

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ MALE or FEMALE RACE \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

MARITAL STATUS: Single Married Widowed EMAIL ADDRESS: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_ PHONE: \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

REFERRING  
PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

**\*EMERGENCY**

CONTACT(s) \_\_\_\_\_ PHONE: \_\_\_\_\_

\* A person we are able to release information to over the phone or get information from.

RELATIONSHIP TO PATIENT: Spouse Parent Child Brother Sister Friend

Any other persons we are able to release information to on your behalf: \_\_\_\_\_

RELATIONSHIP: Spouse Parent Child Brother Sister Friend Phone #: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

INSURANCE COMPANY \_\_\_\_\_ ID# \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_ POLICY HOLDER'S SSN \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

PATIENT'S RELATIONSHIP TO POLICY HOLDER: SELF SPOUSE CHILD

INSURANCE COMPANY PHONE NUMBER: \_\_\_\_\_

**CONTINUED ON BACK!**

**SECONDARY INSURANCE INFORMATION**

INSURANCE COMPANY \_\_\_\_\_ ID# \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_ POLICY HOLDER'S SSN \_\_\_\_\_

POLICY HOLDERS NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT:     SELF    SPOUSE    CHILD    PARENT

INSURANCE COMPANY PHONE NUMBER: \_\_\_\_\_

**AUTHORIZATION TO COLLECT/RELEASE MEDICAL RECORDS**

I hereby authorize Houston Cardiac Surgery Associates, LLP, Houston Vein Institute, Donald M. Gibson, M.D., and/or Miguel A. Gomez, M.D. to collect any and all medical records from referring and other physicians or medical facilities as deemed necessary for my care. I also authorize the release of my health information necessary for the processing of insurance claims on my behalf or to other Physicians and/or Facilities deemed necessary to facilitate my care. We do not release protected health information for any purposes other than to facilitate your care and/or getting claims paid on your behalf.

**Signature of Patient /Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**EXPLANATION OF PAYMENT POLICY and RESPONSIBILITY**

I understand it is the responsibility of the patient to obtain a referral from their primary care physician **before** being seen by Houston Cardiac Surgery Associates, LLP, Houston Vein Institute, Dr. Gibson and/or Dr. Gomez if I have a HMO insurance policy. ***There will be a \$30. charge for a no show office visit and a \$50. charge for a no show procedure.*** I understand that the charges incurred for professional services may or may not be covered by my insurance carrier, including Medicare and it will be my responsibility to pay. I understand any part of the bill deemed patient responsibility by my insurance carrier is solely the responsibility of the patient/guardian for payment. If the account becomes delinquent in payment I agree to pay all costs of collection, including but not limited to a reasonable attorney's fee.

I **authorize** treatment by Houston Cardiac Surgery Associates, LLP, Houston Vein Institute, Donald M. Gibson, M.D. and/or Miguel A. Gomez, M.D.

**Signature of Patient /Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_