SKG Heart Center PLLC
Dr. Swati K Gupta M.D.,F.A.C.C
7737 Southwest Freeway Ste 568 Houston, Tx 77074
1250 Creek Way Dr Ste 100(1st window on the right) Sugarland, Tx 77478
Office 713.623.6555 Fax: 713.623.6569

PLEASE WRITE CLEARLY

Full Name:	Date of Birth:	SS#: Sex:
Address:	City:	Zip Code:
Home Number:	Cell Number:	Email:
Race: Hispanic or Latino AfricanAmerican American Indian or Alaska Native Native Hawaiian or Pacific Islander White Asian Preferred Language:		Marital Status:

Referring Physician:	Office Number:	Office Fax:
Primary Physician:	Office Number:	Office Fax:
Emergency Contact:	Relationship:	Phone Number:
Pharmacy:	Phone Number:	Address:

We will file insurance with your provider according to your individual plan. The patient will be responsible for any outstanding deductible, their co-insurance % and/or co-pay. Referral numbers required by some insurance companies must be given at the time of service, otherwise the service becomes the patient's responsibility. For all private insurance companies, the patient will be responsible for payment at time of service. We will provide the necessary information for the patient to file for reimbursement. I hereby authorize payment directly to *SKG HEART CENTER,PLLC* of the medical and/or surgical benefits, otherwise payable to me for services as described, realizing that I am responsible to pay for non-covered services. I, hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.

Patient Signature: **Date:**

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Medication	Dosage/Strength	How Often Taken

Allergies	Reaction

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Medical History

Reason For Todays Visit: ____

Do You Have or Had Any Of The Following: (Circle All That Apply)				
Heart Disease	Chest Pain	Angina	Heart Attack	Angio Plasty/Stint
Bypass Surgery	Murmur	Valve Problem	Valve Surgery	Diet Pills
Congestive Heart Failure	Irregular Heart Rhythm	Fainting	Pacemaker	High: Blood Pressure
Stroke	Brain Hemorrhage	Carotid Surgery	Asthma	Glaucoma
Retinal Hemorrhage	Cataracts	Hiatus Hernia	Emphysema	Bronchitis
Lung Cancer	Liver Problem	Peptic Ulcer	Reflux	Bleeding Ulcer
Colon Cancer	Jaundice	Hepatitis	Gall Bladder	Kidney Stone
Colitis	DVT	Hemorrhoids	Prostate Enlargement	Kidney Failure
Dialysis	Urinary Problems	High Cholesterol	Prostate Cancer	Arthritis
Skin Problems	Epilepsy/Seizure	Diabetes	Poor Circulation	Amputation
Bleeding Problems	Brain Tumor	Depression	Anxiety	Eye Problems
Anemia	Blood Transfusion	Cancer	Other:	

Social History(Y- Yes N-No F-Former S-Socially)

Do you smoke? Y N F	Cigarettes a day:	Packs a day:	How long?:
Do you drink? Y N F S	Per day:	Per week:	
Caffeine Intake	Coffee per day:	Tea per day:	Soda per day:
Illicit Drugs? Y N F S	Per Day:		

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Surgical History

Name Of Procedure	Date/Year

Family History

Family Memeber	Alive/ Deceased	Age	Diabetes	Hypertension	Stroke	Heart Disease	Cancer	Mental Disease
Father								
Mother								
Grandma								
Grandpa								
Brother								
Brother								
Brother								
Sister								
Sister								
Sister								

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Release Of Records Authorization

I, Hereby to Authorize ____

to release health records information on

Patient Name:	Date Of Birth:
Address:	SS#:
City: State: Zip Code:	Phone Number:

For healthcare covering the periods from:__________________ to:______________________

I, Authorize my information to be release to:

SKG Heart Center, PLLC
7737 Southwest Freeway Ste 568 Houston, Texas 77074
1250 Creek Way Ste 150 Sugarland, Texas 77478
Office:713-623-6555 Fax: 713-623-6569

REASON FOR RELEASE OF INFORMATION (Check all appropriate boxes)

☐ Medical Care ☐ Transfer of Care ☐ Personal File
☐ Specialist Consultation ☐ Moving out of area ☐ Insurance Purpose

INFORMATION TO BE DISCLOSED (Check all appropriate boxes)

☐ Complete Health Record ☐ Consultation/Progress Notes ☐ Laboratory Tests
☐ History and Physician Exam ☐ Billing Records ☐ Ultrasounds ☐ Stress Test/TMT

Patient Signature:____

This Authorization will remain in effect until revoked in writing. The physician and employee are released from any legal responsibility or liability for disclosure of the above information t the extent and authorized herein.

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Consent For Communication Of Protected Health Information

I,____, give my consent to

SKG Heart Center, PLLC to release protected health information to the following people:

Name	Relationship	Phone Number
______________________	____________________	____________________
______________________	____________________	____________________
______________________	____________________	____________________

OR ☐ No other person(s)

- Phone Numbers would you like to receive calls and text regarding appointments, financial, or medical information.

  1)________________________________ 2)________________________________

- May appointments, financial, or medical information be left on your answering machine or voicemail? ☐ Yes ☐ No
- Email for patient portal: ____

Patient Signature:______________________________________ Date:____________________

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Patient Agreement

Patient Responsibility

*You are responsible to provided SKG Heart Center, PLLC with accurate insurance/billing information for yourself or family member at the time of service. Presenting an invalid or inactive insurance card, will result in full payment by you or delay to verify insurance.
*Inform SKG Heart Center, PLLC if any address, phone number, email, or responsible party has changed.
*If you enroll to a new insurance please inform SKG Heart Center, PLLC 7 days prior to your appointment to prevent delays.
*If you need medication refills please contact your pharmacy 1 week before running out of medications. They will send a refill request and we can refill all medications quickly that way.
*To keep up follow-ups for refills, test results, and health care
*$25 NO SHOW FEE.
*If a cardiac clearance is needed, schedule appointment 2 to 3 prior to your scheduled procedure date due to if any cardiac tests are required
*If any paper work is needing to be filled out. Please allow 5-7 business days. Payment is due when papers are picked up.

Co-Payment

*Your insurance company requires you to pay your copay at the time of each visit.
*Your copay may be paid in cash, check, credit card, or debit card.
*If your check is returned a $25 return check fee will be assessed.
*If you do not have medical insurance, you will be expected to pay the starting fee for self pay patients at $250 and up at the time of service.
*Medical insurance does not always cover the entire cost of your medical care. If a service we offer is not covered by your insurance. We will inform you. In some instance, however we would not know, if the service is covered until we submit the claim. You are responsible for the payment If your insurance company refuses to pay for the services.

Deductibles

*It is your responsibility to understand any deductible that may apply to you under your insurance policy.
*Our billing department will send you a statement of the amount your insurance company has determine which is applied to your deductible and is owed by you.
* Our biller is available to provide you with assistance, but will not resolve disputes between you and your insurance company.

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize SKG Heart Center, PLLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions. Recent changes in insurance regulations shorten the time frame for claim submission. I agree to pay any out of pocket expense in full within 30 days from date of service.

Patient Signature: ____ Date: ____________________ ☐ Patient Refuse