YASSIR SONBOL
MD PA
COMPLETE CARDIOLOGY CARE
YOUR HEART IN HANDS YOU TRUST

7102 Tarrington Ave, Suite 202
Sugar Land, TX 77478
PHONE: 281-912-3866 | **FAX**: 844-731-3021

NEW PATIENT INFORMATION

Patient Name/Nombre: _____

Date of Birth/Fecha de Nacimiento: _____

Address/Direccion: _____ **Apt #:** _____

City/Ciudad: _____ **State/Estado:** _____ **Zip/Codigo Postal:** _____

Home Phone/Tel: _____ **Cell Phone:** _____

Height/Altura: _____ **Weight/Peso:** _____

Email address/Correo Electronico: _____

Please check one of the following:

GENDER: ☐ MALE/Hombre **or** ☐ FEMALE/Mujer

MARITAL STATUS: ☐ SINGLE/Soltero ☐ MARRIED/Casado ☐ DIVORCED/Divorciado ☐ WIDOWED/Viudo

ETHNICITY:
☐ American Indian/Asian ☐ Asian ☐ Two or more races ☐ Black/African American ☐ White/Caucasian ☐ Native American/Hawaiian ☐ Some other race

RACE: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Refused

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Referring Doctor: _____ **Phone #:** _____

Fax #: _____ **Reason for Referral:** _____

Primary Care Physician/Doctor de Cabezera: _____

Phone/Telefono#: _____ **Fax #:** _____

Has patient had a recent EKG or ECG? If so, where? _____

If not referred from another physician, how did you hear about us?

☐ Sugar Land Community Magazine ☐ Facebook ☐ Fort Bend Focus ☐ Internet/Google ☐ Absolutely Brazos ☐ Other: _____

EMERGENCY CONTACT INFORMATION/
CONTACTO DE EMERGENCIA

Name: _____ Relationship: _____

Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Authorized Person/
Persona Autorizada para darle información Médica de Paciente:

(Dr.Yassir Sonbol's Office is Authorized to speak to the person below about my Health)

Authorized Name/Nombre: _____

Relationship/Relacion: _____

Cell Phone: _____ Home Phone: _____

Signature/Firma: _____ Date/Fecha: _____

MEDICATION LIST/LISTA DE MEDICAMENTOS

	Name of Medication	**Dosage** (mg/mcg)	**How many times per day?**	**Form** (pill, liquid, inj..)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Allergies to any medications? _____

Reaction to those medications: _____

_____

Pharmacy Information/Información de Farmacia

Retail Pharmacy (Example: Walgreens, CVS, etc.):

Name/Nombre: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone/Telefono : _____ Fax #: _____

Mail Delivery Pharmacy (Example: Medco/Express Scripts, etc.):

Name/Nombre: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone/Telefono : _____ Fax #: _____

Signature/Firma: _____ Date/Fecha: _____

Vein Screening Questionnaire/Cuesionario de Venas

Patient Name/Nombre de Paciente: _____ **Date/Fecha:** _____

(Please check ones that apply to you):

Varicose vein problems	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Leg or Ankle Ulcers	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Spider Veins	☐ Y ☐ N	**Leg:** ☐ R ☐ L

====== Do you experience any of the following in your leg(s)?

Aching/Pain	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Heaviness	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Tiredness/Fatigue	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Itching/Burning	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Swelling	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Cramps	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Restless Legs	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Throbbing	☐ Y ☐ N	**Leg:** ☐ R ☐ L
Skin or ulcer problems	☐ Y ☐ N	**Leg:** ☐ R ☐ L

===== Do you do any of the following to improve the discomfort in your leg(s)?

Take medication for pain	☐ Y ☐ N	**What?** _____
Elevate your legs	☐ Y ☐ N	**What?** _____
Wear support hose	☐ Y ☐ N	**How long?** _____

===== Personal and Family History:

Does anyone in your family have varicose veins?	☐ Y ☐ N	**If yes, who?** _____
Have you ever been pregnant?	☐ Y ☐ N	**If yes, how many times?** _____
Do you sit or stand for long?	☐ Y ☐ N	**For how long?** _____ (periods of time)
Do you exercise regularly?	☐ Y ☐ N	**How often?** _____

Cardiac History Screening/Questionnaire

Patient Name/Nombre de Paciente: _____ **Date/Fecha:**_____

***(Please check all that apply)*:**

- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Heart Attack Date/Year: _____
- ☐ Stroke Date/Year: _____
- ☐ Coronary Artery Disease
- ☐ Arrhythmia
- ☐ Anything else not listed that you would like Dr. Sonbol to know:_____

_____

Have you ever had a…?

***(Please check all that apply)*:**

- ☐ Stress Test Date/Location?_____
- ☐ Echo Date/Location?_____
- ☐ Venous Ultrasound Date/Location?_____
- ☐ Arterial Ultrasound Date/Location?_____
- ☐ Venous Ablation Date/Location?_____
- ☐ Peripheral Angiogram Date/Location?_____
- ☐ Left/Right Heart Cath Date/Location?_____
- ☐ Carotid Ultrasound Date/Location?_____
- ☐ Stent Date/Location?_____

Request for Medical Record Release/
Solicitud de Registros Medicos

YASSIR SONBOL, MD PA
Board Certificate in Cardiology and Interventional Cardiology
7102 TARRINGTON AVE, SUITE 202
SUGAR LAND, TX. 77478
PHONE: 281-912-3866 **FAX:** 844-731-3021

The following individual has asked us to request that their medical records be released and forwarded to our office.

Patient/Paciente: _____

Birthdate/Fecha de Nacimiento: _____

Social Security/Seguro Social #: _____

In order for us to fully evaluate the patients' health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include all lab reports as well as office notes.

Thank you for expediting this request. Please mail or fax these records to our office address shown above.

I hereby authorize the release of all necessary medical records to Dr. Yassir Sonbol, MD. I wish for them to be forwarded as soon as possible.

Patient Signature/Firma: _____ **Date/Firma:** _____

Patient Address/Direccion: _____

Apt. #: _____ **City:** _____ **State:** _____ **Zip:** _____

HIPAA NOTICE OF PRIVACY PRACTICES
Aviso de Practicas de Privacidad de HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. • Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

We will not use or share your medical information for any other reason unless you give us written permission. You may withdraw your permission in writing at any time. Your permission for us to use or share your information will end when we get your written notice that you have withdrawn your permission.

I understand that I may request in writing that this organization may restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Your rights. You may ask us in writing to do any of the following. We will decide if it can be done based on the Privacy Protection Standards outlined in HIPAA.

- You may ask us to use or share your medical information.
- You may ask us to contact you about your medical information privately in a different way or different place than we are currently doing.
- You may ask to see or obtain copies of your medical information. You may be charged for copies.
- You may ask us to correct your medical information.

Complaints: If you believe we have not protected your right to privacy, you have the right to complain to us or the Secretary of the U.S Department of Health and Human Services.

I understand and accept the terms of YASSIR SONBOL, MD PA practice.

Signature/Firma: _____ **Date/Fecha:** _____

Cancellation Policy/No Show Policy For Dr. Appointments
Politica de Cancelacion/No Presentarse a Su Cita

Cancelation/No show policy for doctors appointments

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule your visit, due to a seemingly "full" appointment book.

(Patient initial/ Paciente Inicial: _____)

We also reserve the right to charge for a missed appointment when you fail to provide notice that you will not honor your appointment without good cause. Please call our office 24 business hours prior to a scheduled appointment to avoid charges (excludes weekend). Your failure to timely cancel an appointment will result in a charge of Thirty Dollars ($30.00) for missed medical appointments. This assessment becomes your personal and individual responsibility and cannot be charged to your insurance or third-party carrier.

(Patient initial/ Paciente Inicial: _____)

For your convenience, accounts can be paid using MasterCard, Visa, and Discover Card, as well as check and cash. We thank you for choosing Yassir Sonbol, MD PA for your Cardiology care and look forward to serving you.

Print Patient Name (Imprimir Nombre): _____ **Date of Birth:** _____

Patient Signature (Firma): _____ **Date:** _____

PATIENT ACCOUNT BILLING AND DISCLOSURE NOTICE
AVISO DE FACTURACIÓN Y DIVULGACIÓN

Please be advised that Yassir Sonbol MD PA, maintains a Patient Billing and Disclosure Policy as of 01/01/2017, (the "Policy") which is outlined below. You should read the Policy and ask any questions you may have regarding its effect or operation. By your signature below, Yassir Sonbol MD PA hereby acknowledges your receipt, understanding and consent to the following terms and conditions.

Once we have received payment in full from your primary insurance (and/or secondary insurance carrier if applicable). You will receive an invoice for that portion of the invoice balance which remained unpaid by any insurance or third party carrier ("Patient Owed Balance"). Such balances, for example, are usually for unpaid copayments, non-medical deductibles or non-covered services per your particular plan's benefits.

We will bill you for all charges for a particular date of service that has been paid by your insurance or third party carrier(s). You may still have claims that are being processed for other dates of service. However, we invoice you based on a specific date of service for which insurance payments have been received in full in order to clear the remaining balance for the date of service. Your INSURANCE CO-PAY and any PATIENT OWED BALANCE are DUE IN

FULL at each visit. If these patient responsibilities cannot be met then we will have to reschedule your appointment. For information on your CO-PAY, call your insurance carrier. For information on your PATIENT OWED BALANCE, please call billing at 877-745-7751 or the office at 281-912-3866.

Please read the following carefully. You should receive an Explanation of Benefits (EOB) from your insurance detailing your patient responsibility (patient owed balance) for your services. Please pay your balance in full from this initial insurance notice. Yassir Sonbol MD PA will send out 1-3 invoices reflecting the Patient Owed Amount depending on the remaining balance. If payment in full on your Patient Owed Balance is not received within a thirty (30) day period, your outstanding account may be turned over to a collection agency without any additional notice to you. Invoices, which are turned over to a collection agency, are immediately deemed Delinquent Accounts. Any Delinquent count is discharged from further care and services until the Delinquent Account is paid in full.

ADDITIONALLY, IF YOU DESIRE OUR SERVICES AND CARE IN THE FUTURE YOU MUST REINSTATE YOUR ACCOUNT BY PAYING ALL COLLECTION FEES AND COST INCURRED BY YASSIR SONBOL MD PA. THESE FEES NORMALLY INCLUDE 35% CHARGED BY THE COLLECTION AGENCY THAT RECOVERED PAYMENT OF YOUR OUTSTANDING AND UNPAID ACCOUNT. WE RESERVE THE RIGHT TO REFUSE FUTURE SERVICES UNTIL SUCH FEES AND COSTS ARE PAID IN FULL. ALSO, PLEASE NOTE THAT PAYMENT OF SUCH FEES ARE IN ADDITION TO ANY NEW SERVICES RENDERED BY YASSIR SONBOL MD PA.

For your convenience accounts can be paid using your MasterCard, Visa and Discover Card as well as check and cash. We thank you for choosing Yassir Sonbol MD PA for your cardiology care and look forward to serving you.

Print Patient Name/Imprimir Nombre: _____

Date of Birth/Fecha de Nacimiento: _____

Patient Signature/Firma: _____ **Date/Fecha:** _____