HEART VASCULAR & SPORTS CARDIOLOGY
CLINIC OF HOUSTON

8731 Katy Fwy., Suite 420
Houston, TX 7024
(O) 832-376-8911 (F) 832-510-1650
www.hvschtx.com
Kevin A. Lisman, MD

Hello and welcome to Heart Vascular & Sports Cardiology Clinic of Houston

Please fill out these forms completely and return them to us as soon as possible, as this will expedite your waiting time on the day of your appointment. This will also help us to verify your insurance information and assist your physician in assessing your cardiac condition.

Please complete your forms online via the Healow Portal.

If you have any questions, please feel free to contact us at **832-376-8911**.

Thank you,

Heart Vascular & Sports Cardiology Clinic of Houston

HEART VASCULAR & SPORTS CARDIOLOGY CLINIC OF HOUSTON

PATIENT INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____

SS#: _____ Sex: M / F / Undiff Date of Birth: _____ Marital Status: M D S W

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Email: _____

Employer's Address: _____

Work Status: ☐ Full Time ☐ Part Time ☐ Retired Date: _____ Student Status: ☐ Full Time ☐ Part Time

Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other: _____

Primary/Secondary Language: _____ Preferred Language: _____

Preferred choice of Communication Method:

☐ Email: _____ ☐ Phone: _____ ☐ Mail: _____

Referring Doctor: _____

SPOUSE / GUARDIAN INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____

SS#: _____ Sex: M / F / Undiff Date of Birth: _____ Marital Status: M D S W

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Work Phone: _____ Employer: _____

Employer's Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____

Secondary Insurance: _____ Policy Holder: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Other Phone: _____

PAYMENT POLICY

Heart Vascular & Sports Cardiology Clinic of Houston will file a claim on your behalf to your insurance company. The patient's anticipated portion (including co-pay, deductible and/or percentage) is the only amount due today.

Preferred Method of Payment:

☐ Cash ☐ Check ☐ Credit Card

Authorization to release information & assignment of benefits:

I hereby authorize payment directly to Heart Vascular & Sports Cardiology Clinic of Houston for benefits otherwise payable for medical/professional services rendered to me. I further authorize the release of information acquired in the course of my examination or treatment which is necessary to process an insurance claim. Heart Vascular & Sports Cardiology Clinic of Houston is authorized to inquire as to the status of insurance claim(s) which have been filed on my behalf. A copy of this authorization is as valid as the original which remains effective one (1) year from the date signed.

I understand that I, the patient/guardian, remain liable for all charges incurred by me, regardless of any insurance coverage, and any problems with the insurance carrier are between the insured and the insurance company.

Signature: _____ Date: _____

HEART VASCULAR & SPORTS CARDIOLOGY CLINIC OF HOUSTON

Receipt of Notice of Privacy Practices Written Acknowledgment Form / Authorization to Release Protected Health Information to Personal Representatives

In compliance with the Health Information Portability and Accountability Act (HIPAA) and because it is our sincere desire to protect your right to privacy, we are implementing a policy requiring your written authorization before allowing us to disclose or discuss your personal information with any personal representative effective January 2026. To further protect your right to privacy, we are also required by HIPAA to acquire written acknowledgement that you have received our Notice of Privacy Practices.

If you have any questions regarding this form or policy, you may direct them to our HIPAA Coordinator, Michael Shirley, at 832-376-8911.

I, (Patient Name) _____, acknowledge and agree that I have received a copy of Heart Vascular & Sports Cardiology Clinic of Houston Notice of Privacy Practices.

***

I hereby authorize Heart Vascular & Sports Cardiology Clinic of Houston to disclose information about my account, evaluation and/or treatment to:

EXAMPLE:

__JANE DOE_____	**____SPOUSE____**	**__(832) 555-5555____**
Name	Relationship	Phone
1) _____	_____	_____
Name	Relationship	Phone
2) _____	_____	_____
Name	Relationship	Phone
3) _____	_____	_____
Name	Relationship	Phone

SIGNED: _____ DATE: _____

This consent is subject to written revocation by the above signed at any time except to the extent that action has been taken. I hereby release the aforementioned facility from any/all legal liability that may arise from the release of this information to the party named above. A copy or fax of this authorization is as valid as the original.

MEDICAL HISTORY

DATE:_____

NAME_____ **BIRTH DATE** _____ **AGE**_____

LAST FIRST MIDDLE INITIAL

Social Security #: _____

Referring Physician (Address incl. City/State/ZIP): _____

Who is financially responsible for your medical care?

_____

Problems: (State reasons you want to see a doctor. List in order of importance to you).

1. _____
2. _____
3. _____
4. _____

List other physicians seen in last two years and why:

_____

_____

PAST MEDICAL HISTORY

1. **Illnesses (requiring hospitalization – list problem and year)**

_____

_____

_____

2. **Accidents (broken bones, injuries, etc.)**

_____

_____

_____

3. **Operations (list all and year)**

_____

_____

_____

4. **Allergies** (have you had reactions to any of the following medications (yes or no) and describe the reaction; For Example, “rash, asthma, hives, blackout”)

Penicillin	Demerol
Sulfa	Barbiturates
Aspirin	Anesthetics
Codeine	Other

5. **Pregnancies:** _____ **Miscarriages:** _____ Weight of largest child at birth: _____

6. **Medications** (List all you are now taking or have taken (in the past month) and indicate how often you have taken them): Bring ALL medications with you.

_____

_____

_____

How much of the following have you been taking:

Aspirin: _____ Laxatives: _____ Oral contraceptive: _____ Sleeping pills: _____

FAMILY HISTORY	AGE	STATE OF HEALTH	CAUSE OF DEATH
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
BROTHERS	_____ _____ _____	_____ _____ _____	_____ _____ _____
SISTERS	_____ _____ _____	_____ _____ _____	_____ _____ _____

SPOUSE	_____	_____	_____
CHILDREN **(circle one)** **M F** **M F** **M F** **M F**	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

FAMILY HISTORY	FATHER	MOTHER	SISTER(S)	BROTHER(S)	OTHER
Goiter					
Cancer					
Tuberculosis					
Allergies or asthma					
Strokes					
Nervous breakdown					
Suicide					
Convulsions/epilepsy					
Headaches					
Diabetes					
Arthritis					
Heart Attack					
High Blood Pressure					
Gout					
Kidney Stone					
Bleeding problem					
Ulcers					
Stroke or heart attack prior to age 60					

REVIEW OF SYSTEMS: Review the list below and INDICATE any number that describes a problem you are currently having and UNDERLINE those problems you have frequently had in the past.

Headaches	Constipation, chronic	Swelling of legs
Seizures or fits	Vomit blood	Cough
Numbness or tingling in hands, feet, arms or legs	Have blood with bowel movements	Cough up blood
Weakness in hands, feet, arms or legs	Black, loose bowel movements	Wheezing during breathing
Difficulty maintaining balance	Stomach pain	Sugar diabetes
Dizziness	Jaundice (yellow skin)	High blood pressure
Fainting or blackout spells	Stomach ulcers	Night sweats
Strokes	Hemorrhoids	Continuous fever for greater than 5 days
Ringing in ears	Weight loss	Nausea, chronic
Difficulty with hearing	Weight gain in past year	Trouble with swallowing
Difficulty with vision	Loss of appetite	Vomiting
Double vision	Frequent urination or passing water	Diarrhea, chronic
Difficulty smelling things	Urination at night	Duration of menstruation (days): _____
Excessive sneezing	Pain on urination	Length of interval between periods: _____
Trouble breathing through nose	Pus or milky color of urine	Bleeding between periods
Nose bleeds	Blood in urine	Painful periods
Change in voice	Pass a stone in urine	Irregular periods
Shortness of breath at night	Reduction in force or size of urine	Last menstrual period: _____
Shortness of breath while walking	Difficulty starting urine stream	Last pelvic exam: _____
Swelling of ankles or feet	Leakage of urine	Vaginal discharge
Palpitations	Difficulty with erection	Onset of menstruation (age): _____

Chest pain or tightness in chest	Difficulty with ejaculation	High cholesterol
Heart attacks	Discharge from penis	
Back pain – high	Excessive bleeding after cutting skin	Painful breast
Back pain – low	Crying spells	Excessive blistering after sun exposure
Change in glove/shoe/hat size	Insomnia	Change in facial appearance
Muscle cramps in arms, legs, hands or feet	Mood swings	Easy bruising
Pain in legs while walking	Nervousness	Hives
Joint swelling	Difficulty with memory	Excessive sweating
Joint pain	Problem with thinking clearly	Prefer hot water
Pain in hands or feet on cold exposure	Chronic fatigue or weakness	Prefer cold water
Skin rash	Depression and anxiety	Breast discharge
Dry skin	Itching of skin	Lumps in breast
Increase in hair growth	Skin pallor	Loss of hair
Increase in oiliness of skin		

Weight Age 20:_____ **Weight 1 year ago:**_____ **Weight now:**_____

PERSONAL HISTORY

1. Occupation (Yours): _____ Spouse's: _____

2. Place of employment: _____

3. Education (circle level completed): High School (9 10 11 12) College (1 2 3 4) Masters Ph.D. Other

4. Marital status (circle): Single Married Widowed Separated Divorced

5. Religious preference: _____

6. Hobbies (list): _____

7. Smoking history: Packs each day _____ For how many years? _____

8. Drinking history: Ounces each day? _____ For how long in years? _____

9. List the individuals that live in your home: _____

10. Emergency contact (name, address, phone, relationship to you): _____

11. Exercise (circle): walking / jogging / bicycling / swimming / golf / tennis / other

Minutes each day _____ Hours per week _____ Moderate occupational & recreational exercise? _____

Sedentary work and light exercise only? _____

14. What additional information should the doctor have about you? _____

15. Comments: _____

Patient's Signature: _____ Date: _____

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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

		Example
Treat you	We can use your health information and share it with other professionals who are treating you.	A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization	We can use and share your health information to run our practice, improve your care, and contact you when necessary.	We use health information about you to manage your treatment and services.
Bill for your services	We can use and share your health information to bill and get payment from health plans or other entities.	We give information about you to your health insurance plan so it will pay for your services.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Help with public health and safety issues

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or maintain psychotherapy notes at this practice.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective: 01/01/2026

This Notice of Privacy Practices applies to the following organizations.

Privacy Contact:
Michael Shirley
Phone: 832-376-8911

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Houston, TX 77024
info@hvschtx.com