ASN Cardiology
11914 Astoria Blvd, Ste 100, Houston, TX 77089
3129 Kingsley Dr, Suite 340, Pearland, TX 77584
Phone: 832-328-8551
Email: cardio.houston22@gmail.com

New Patient Form

Name: DOB:

SSN: Gender: Race:

Referred by: Primary Care Doctor:

Home phone: Cell phone:

Email:

Address:

City: State: Zip code:

Preferred pharmacy: Pharmacy phone:

Pharmacy address:

Emergency Contact Name and Number

Name: Relationship:

Phone number:

Primary Insurance Policy Holder (if not patient)

Name: DOB: Phone number:

Address: City: State: Zip code:

Relation to the patient:

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Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize ASN Cardiology staff to apply for benefits on my behalf for covered services rendered by him or by his orders. I request that payments from the insurance company be made directly to ASN Cardiology. I certify that the information I have reported with regards to my insurance coverage is accurate. The authorization may be revoked by either me or my insurance company at any time in writing.

Signature (Patient or Patient Representative) Date

Cancellation Policy

Please be advised that our office has a **48-hour cancellation policy for all appointments.** If you are unable to keep your scheduled appointment, we kindly ask for at least 48 hours' notice. This allows us to accommodate other patients who may require medical attention.

Appointments canceled or rescheduled within less than 48 hours of the scheduled time may be subject to a $25 cancellation fee.

We understand that unforeseen circumstances may arise, and we appreciate your prompt notification should you need to change or cancel your appointment. To do so, please contact our office during regular business hours and speak with our staff to make the necessary changes to your appointment.

Thank you for your understanding and cooperation in helping us maintain an efficient and effective appointment schedule.

By signing your name, you understand and agree to our policy.

Signature (Patient or Patient Representative) Date

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HIPAA Form

In accordance with HIPAA regulations, we cannot engage in discussions about a patient's health information over the phone with individuals other than the patient themselves. The patient has the right to designate one additional individual, such as a spouse, child, neighbor, or friend, to discuss matters pertaining to their health. Each patient is allowed to assign only one such representative. In situations where multiple family members are involved, we kindly request that the family coordinate and choose a single representative. Should you have any inquiries or concerns, please feel free to reach out to us.

I, _____, give permission to _____
Name of the patient Name of the designated individual

to discuss my health information with Dr. Garg and his staff.

Signature of patient:_____

Relationship of designated individual to the patient:_____

Phone number of designated individual: _____

Witness:_____

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Record Release Form

I hereby authorize the release of any information including diagnosis and records of any treatment, examination, or surgery rendered to me during the periods of _____ to _____ to be sent to Dr. Garg/ASN Cardiology.

Doctor's Name: _____

Address: _____

_____

Telephone:_____

Fax Number:_____

***Patient Name:_____**

***DOB:_____**

***Signature:_____**

Witness:_____

*Please ensure that fields marked with a star are completed as a minimum requirement. If we require records from your doctor, this form will be kept on file, enabling us to fill in the necessary information for the records request. Thank you for your cooperation.