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San Francisco CA 94118

1580 Valencia Street
Suite 412
San Francisco CA 94110

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Suite 516
San Francisco CA 94115

PATIENT REGISTRATION FORMS

This packet contains 4 documents:

- Patient Registration Form
- Patient Consent Form
- Financial Policies
- Confidential Health Questionnaire

Please bring the completed packet to your appointment.

PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

Print Name

Date

Signature

FINANCIAL POLICIES

We are committed to providing the best medical care. We also want to help you receive your maximum allowable benefits if you have medical insurance. In order to do so, we need your partnership and your clear *understanding of our financial policies*. Therefore, we ask that you read and understand the following:

1. Your insurance is a unique contract between you, your employer, and your insurance company. ***Not all services are covered by all insurance plans*** (for example, a routine physical exam is not covered under Medicare or some PPO plans.) This is not to be confused with the physician's determination of which services are medically necessary or appropriate.

2. Our staff cannot possibly know all the details of your policy. It is in your best interest to know and understand your benefits, deductible, co-payments, etc. **before** you seek services. If you have questions as to what is covered by your insurance, call the insurance company directly. We recommend that you record the name of the person with whom you speak, the date, and the phone number called; this provides important documentation if your claim is later denied, or if services are not covered as represented to you. When reviewing your written policy, be sure to review the "Exclusions" page, as services which appear to be covered in the body of the policy may be excluded there.

3. Our physicians have a **medical care relationship with you**, separate from any contractual agreements with insurance companies. Because you are the recipient of services, all charges are your responsibility from the date the services are provided. **We cannot legally bill your insurance for services without your permission and cooperation. You are responsible for charges not covered by your insurance, and payment must be made as soon as responsibility is determined.**

4. If you have coverage through a plan in which we participate, we will collect your co-payment, if any, at the time of service. We will bill your insurance for services only if you have supplied us with current, complete, and verifiable information. California Pacific Cardiovascular Medical Group policy is to have patients bring your current insurance card to every appointment. We also request that you send us a copy of any new card you receive for new or continuing insurance.

5. Co-payments and payments toward your deductible must be paid at the time of service.

6. The balance remaining after the insurance portion is paid or denied is due within 30 days. If you disagree with the insurance determined benefit, you must contact your insurance directly.

7. If your coverage is not verifiable at the time of your visit, **we will require your full payment for care at that time**. In this case, we will provide you with a detailed receipt that you may submit to your insurance for reimbursement.

8. If you do not have insurance, or have insurance with which we are not contracted, payment must be made when you arrive for your appointment.

9. Returned checks will be subject to an additional \$25 fee.

(continued)

(FINANCIAL POLICIES FORM continued)

10. We will gladly discuss your estimated medical care costs; however, your provider determines actual costs at the time services are provided.

11. We realize that temporary financial problems may affect timely payment of your account. If such problems occur, contact our billing staff promptly to make arrangements.

SPECIAL SERVICES

Missed Appointment Fee for NIL Tests

We set aside valuable lab equipment, technician, and physician time when scheduling noninvasive tests. Too often, an appointment is not kept, or is cancelled with too little notice to schedule the lab time with another patient. Therefore, our policy now requires \$150 payment for any nuclear test (thallium or persantine thallium) that are not kept, or cancelled or rescheduled with less than 24 hours notice (only business days included). The fee for missed appointments for echo and stress echocardiogram, treadmill and holter is \$100.

A nominal fee must also be charged to cover our costs when we send a copy of your records to you, to another provider (unless we are referring you), or for disability or other legal claims. This fee is \$25.

UNDERSTANDING AND AGREEMENT

I understand and accept that, regardless of my insurance status, I am responsible for prompt payment of all charges for medical care and other services provided by the California Pacific Cardiovascular Medical Group. I have read the financial policy and completed the "Patient Information" form. I certify that this information is true and correct, to the best of my knowledge, and will notify you of any changes.

This is my direct assignment of payment as defined in the rights and benefits of my insurance policy, where I assign and instruct direct payment to California Pacific Cardiovascular Medical Group, or to an individual physician member, the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges of the professional medical care provided to me. The payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional charges over and above insurance payment, as due. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize release of any information required of my insurance to process a specific claim.

Patient/Claimant Signature

Date

Parent, if patient is a minor

Date

CONFIDENTIAL HEALTH QUESTIONNAIRE

Print Name _____

Appointment Date _____

Date of Birth _____

Age _____

Primary Care Doctor _____

MEDICATIONS

Please bring all medications that you are currently taking to the office for your consultation appointment. Please also list them below or on a separate sheet.

	Medication	Dosage		Medication	Dosage
1			8		
2			9		
3			10		
4			11		
5			12		
6			13		
7			14		

1. CURRENT SYMPTOMS

Which symptoms are you being referred for?

	When did it first begin?	How often does it happen?
Chest pain / pressure		
Shortness of breath		
Palpitations		
Dizziness		
Blackout spells		
Ankle swelling		
Leg cramping		

(continued)

(CONFIDENTIAL HEALTH QUESTIONNAIRE continued)

2. PAST MEDICAL ILLNESS

A. MEDICAL ILLNESS

Please check the conditions which you have and list the year of diagnosis.

<input checked="" type="checkbox"/>	Year	<input checked="" type="checkbox"/>	Year
<input type="checkbox"/> Hypertension (high blood pressure)		<input type="checkbox"/> Bleeding problems	
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Thrombosis / Blood Clots	
<input type="checkbox"/> Hyperlipidemia (high cholesterol)		<input type="checkbox"/> Infections	
<input type="checkbox"/> Thyroid Disease		<input type="checkbox"/> Cancer	
<input type="checkbox"/> Liver Disease / Hepatitis		<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Other (write in)			

B. SURGERIES

Type of Operation	Year	Hospital	City, State

Blood Transfusion	Year	Number of Units

C. HOSPITALIZATIONS (for non-surgical problems)

Problem	Year	Hospital	City, State

D. DRUG ALLERGIES

Type of reaction. For example: Penicillin → Skin rash

Drug	Reaction

(continued)

(CONFIDENTIAL HEALTH QUESTIONNAIRE continued)

E. TOBACCO USE

- No
 Yes Packs per day:____ Number of years:____ Year in which you stopped:____

F. ALCOHOL USE

- No
 Yes Drinks per day:____ Number of years:____ Year in which you stopped:____

3. FAMILY HISTORY

	Father	Mother	Siblings
Heart Disease			
Hyperlipidemia (high cholesterol)			
Stroke			
Hypertension (high blood pressure)			
Diabetes			
Bleeding Disorder			
Thyroid Disease			
Cause of Death			

4. SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Number of Children: ____ Ages: ____ ____ ____ ____

Work Status: Unemployed Retired Misc

CONCERNS / QUESTIONS

If you have any specific concerns or questions, please list them below.
