CALIFORNIA CARDIOVASCULAR INSTITUTE - CENTRAL COAST

Patient Registration Form

Last Name	*First Name*	*MI*	*Date of Birth (MM/DD/YYYY)*	*Gender* ❑ **Male** ❑ **Female**
Previous / Other Name to Use	*Social Security Number*	*Marital Status* ❑ **Single** ❑ **Married** ❑ **Widow/er** ❑ **Divorced**		
Street Address		*City*	*State*	*Zip Code*
Home Phone (❑ **May leave message***)*	*Cell Phone (*❑ **May leave message***)*	*Email address (*❑ **I do not use email***)*		

❑ **By checking this box, you are giving us permission to send you important notifications via text, email or Patient Portal message.**

Primary Language ❑ **English** ❑ **Spanish** ❑ **Other:**	*Race* ❑ **American Indian/Alaska Native** ❑ **Asian** ❑ **Black/African American** ❑ **Hispanic** ❑ **White/Caucasian** ❑ **Other:**	*Ethnicity* ❑ **Hispanic** ❑ **Not Hispanic** ❑ **Declined**

Name of Responsible Party (❑ **Self***)*	*Relationship to Patient*	*Phone Number*	*Address (*❑ **Same as above***)*
Primary Occupation (❑ **Retired***)*	*Employer*	*Work Phone Number*	*Work Address*
Primary Insurance Carrier	*Subscriber Name & Relationship to Patient*	*Subscriber ID*	*Group Number*
Secondary Insurance Carrier	*Subscriber Name & Relationship to Patient*	*Subscriber ID*	*Group Number*

Emergency Contact Name (❑ **HIPAA***)*	*Relationship to Patient*	*Phone Number*	*Address (*❑ **Same as above***)*
Emergency Contact Name (❑ **HIPAA***)*	*Relationship to Patient*	*Phone Number*	*Address (*❑ **Same as above***)*

I authorize California Cardiovascular Institute – Central Coast to provide information to my contacts listed above in the event there is an emergency. If I would like my complete or a portion of my medical records released, I will do so by completing an Authorization for Use or Disclosure of Protected Health Information. This form is available upon request, or I can choose the HIPAA option next to the emergency contacts as an alternative.

Signature of Patient or Legal Representative	*Relationship to Patient*	*Date Signed*

Primary Provider Name	*Practice Name & Address/Location*	*Phone Number*
Referring Provider Name	*Practice Name & Address/Location*	*Phone Number*

Local Pharmacy Name	*Address/Location*	*Phone Number*
Mail-Order Pharmacy Name	*Address/Location*	*Phone Number*

I authorize California Cardiovascular Institute - Central Coast to access and use my full electronic prescription history by any and all of my healthcare providers, including but not limited to hospitals, urgent care, dental, and any other facilities. I am allowing access to my prescription records filled in my name by local, mail order, and specialty pharmacies. I understand this authorization shall not expire unless I submit a written request.

Signature of Patient or Legal Representative	*Relationship to Patient*	*Date Signed*

California Cardiovascular Institute – Central Coast's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. For informational purposes only, the link to federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is https://openpaymentsdata.cms.gov. The Federal Physician Payments Sunshine Act requires the detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturer of drugs, medical devices and biologics to physicians and teaching hospitals be made available to the public.

I acknowledge that I received copies of the above notices/disclosures.

Signature of Patient or Legal Representative	*Relationship to Patient*	*Date Signed*

CALIFORNIA CARDIOVASCULAR INSTITUTE - CENTRAL COAST

FINANCIAL POLICY AGREEMENT

The providers at California Cardiovascular Institute - Central Coast are committed to providing you with superior healthcare. As part of that commitment, it is important for us to establish our financial policy and your responsibilities.

IDENTIFICATION

- In order to prevent identity theft, you will be required to provide us with a government issued picture 1D.
- Copies of all valid insurance cards are required. In the event a card is not available, you must be able to provide us with information so that we may verify insurance coverage and eligibility.

INSURANCE

- If we are unable to verify eligibility and benefits, you will be required to pay for services in full at the time of service.
- While we are contracted with many health plans, we may not be contracted with all health plans. It is your responsibility to provide us with your most current insurance information. Any changes in your insurance coverage must be reported to us immediately. If this information is not provided to us before or at the time of service, or within your insurance's timely filing limits, you will be financially responsible for any services provided.
- As a courtesy, our business office will submit claims to your health plan for services rendered by our office. Our business office will also assist you to the best of their ability to help get your claims paid.
- In the event your claim is delayed or denied payment due to a lack of information from the subscriber, patient, employer, or any entity or person outside of our office will be your financial responsibility.
- Some medical services may be considered by your insurance to be non-covered, out-of-network, or not medically necessary services. Our office will do its due diligence to obtain authorization and verify benefits for services being provided, however it is your responsibility to know your medical coverage and will be your financial responsibility.
- Any co-pays, coinsurances, deductibles and balances are due prior to the rendering of services. In the event we do not collect such amounts at the time of service, it does not waive our right to collect and your financial responsibility for these services. We will do our best to estimate your portions due at the time of service. However, your final balance is determined after your claim is processed by your insurance. Our business office will send you a patient statement of any balances not collected at the time of service.

PAYMENTS

- We accept the following methods of payment; CASH, CHECK, OR CREDIT/DEBIT CARD.
- We understand at times there may be hardships, we encourage you to contact our office for other arrangements if are unable to make any of your expected payments.
- Any patient payments received are applied to the oldest balances first (does not apply to insurance payments).
- If a credit occurs from an advanced payment or after the insurance has finalized the claim we reserve the right to re-apply that credit to any other services with an outstanding balance.

BALANCES

- In accordance with state law, federal law, and any payer contract agreements, we will not waive, fail to collect, or discount any co-pays, co-insurances, deductible, or any other patient financial responsibility.
- Statements will be sent by our business office for any balances due. Payment is due upon receipt, but no later than 30 days from the date of the statement.
- Any past due balances beyond 90 days are subject to late fees, and/or interest fees.
- Our business office will attempt to notify you of your debt by utilizing one or more of the following methods: statements, letters, phone calls, or messages through your patient portal (if you are enrolled).
- Any unpaid balances may be referred to our outside collection agency, and may be subject to additional interest fees, and/or negative credit rating reporting with various credit bureaus.
- In the event you are unable to pay your bill in full, we encourage you to call our office to make reasonable payment arrangements.
- You may also request for financial hardship consideration regarding your balance. However, you may be required to submit personal financial information (i.e. check stubs, bank statements, etc.) in order for us to determine whether or not you qualify.

Patient Initials

RETURNED CHECKS

- A check returned for any reason is subject to a return check fee of $35 per check.
- The returned check fee must be paid by cash, money order, and credit or debit card.
- We may refuse to accept any future check payments.
- We reserve the right to utilize all available legal remedies under California Law, including reporting your returned check to our local District Attorney's office.

MISSED APPOINTMENTS AND LATE ARRIVALS

- We require a cancellation notice of at least 24 hours.
- If you arrive to your appointment more than 5Sminutes late your appointment may need to be rescheduled and you may be subject to or missed appointment fee.
- If 24 hour notice is not given you may be charged a missed appointment fee of at least $50 for provider visits and at least $150 for testing appointments. This fee may be waived at our discretion.
- We understand at times circumstances may not allow for you to cancel within 24 hours, however we ask that you call as soon as possible so that we have the opportunity to offer the appointment to another patient.

FORMS

- Any forms requiring medical review and/or a provider's signature is subject to an administrative fee of $25 per form.
- This fee is due prior to release of any completed forms.

REQUEST FOR MEDICAL RECORDS

- The security of your records is very important to us. Therefore, we require a WRITTEN request for any release of medical records.
- Release of records is subject to an administrative fee of $25 per request plus $0.25 per page if paper copies, or $5 If provided digitally (i.e. CD, etc.).
- Records will NOT be released until the required fees are paid.

BY SIGNING THIS AGREEMENT:

- **I acknowledge that I have read and will comply with California Cardiovascular Institute's Financial Policy as described above. I may request a copy at any time.**
- **I hereby assign all of my applicable health insurance benefits and all rights and obligation that I and my dependents have under my health plan to California Cardiovascular institute – Central Coast and it's representatives and | appoint them as my authorized representative with the power to:**
  - **File medical claims with my health plan**
  - **Be paid directly by my health plan for services rendered to me or my dependents**
  - **File appeals and grievances with my health plan**
  - **Discuss or provide any of my personal health information or that of my dependents with any third party, including my health plan**
- **I certify that I have provided accurate insurance information as of the date below and that I am responsible for keeping it updated.**
- **1 am fully aware that having health insurance does not release me of my responsibility to ensure California Cardiovascular Institute – Central Coast is paid in full.**
- **I hereby authorize California Cardiovascular Institute – Central Coast and its representatives to:**
  - **Release information necessary to my health plan or its administrator regarding my illness and treatments**
  - **Process insurance claims generated in the course of examination or treatment; and**
  - **Allow a photocopy of my signature to be used to process insurance claims.**
- **I understand in order to terminate this agreement I must submit a formal written request to revoke my authorization.**
- **1 understand California Cardiovascular Institute – Central Coast may update or amend its policies without prior notice.**

Signature of Patient or Legal Representative	*Relationship to Patient*	*Date Signed*

CALIFORNIA CARDIOVASCULAR INSTITUTE - CENTRAL COAST

HEALTH APPRAISAL QUESTIONNAIRE

Have you been diagnosed or treated for the following conditions?

Condition	Yes	Month/Year	Condition	Yes	Month/Year
Hypertension	☐		Atrial Fibrillation	☐	
High Cholesterol	☐		Stroke or Mini-Stroke/TIA	☐	
Diabetes mellitus	☐		Peripheral Vascular Disease	☐	
Coronary Heart Disease	☐		Aortic Aneurysm	☐	
Heart Attack	☐		Kidney Disease or Failure	☐	
Congestive Heart Failure	☐		Thyroid Disorder or Surgery	☐	
Cardiomyopathy	☐		Liver Disease or Failure	☐	
Heart Valve Disease	☐		Bleeding Disorder	☐	
Heart Murmur	☐		Past Blood Transfusion	☐	

Other Medical Problems: _____

_____

Cardiovascular Procedures & Surgeries

	Yes	Month/Year & Hospital
Cardiac catheterization or coronary angiogram	☐	
Coronary angioplasty/stent or rotablator	☐	
Coronary artery bypass graft surgery	☐	
Cardiac pacemaker or defibrillator implantation	☐	
Heart valve replacement surgery	☐	
Carotid artery stenting or surgery	☐	
Angioplasty/stent or bypass surgery of the leg arteries	☐	

Other Major Surgeries/Injuries with Dates: _____

_____

Family Cardiovascular History (Parents & Siblings Only)

	Yes	Family Member/s & Age at Diagnosis
Heart Attack / Myocardial Infarction	☐	
Coronary Artery Disease	☐	
Coronary Angioplasty/Stenting or Bypass Surgery	☐	
Other Heart Disease:	☐	
Other Heart Surgery:	☐	
Stroke	☐	
Vascular Surgery	☐	

Social History

	Frequency of Current or Prior Substance Use					
	Never	4-7 days a week	1-3 days a week	Few times a month	Few times a year	Date of Last Use
Cigarette Smoking	☐	☐	☐	☐	☐	
Vape Smoking	☐	☐	☐	☐	☐	
Alcohol	☐	☐	☐	☐	☐	
Marijuana	☐	☐	☐	☐	☐	
Cocaine	☐	☐	☐	☐	☐	
Methamphetamine	☐	☐	☐	☐	☐	
Heroin	☐	☐	☐	☐	☐	
Other Street Drugs	☐	☐	☐	☐	☐	

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MEDICATION HISTORY

Drug Allergies

❑ No known medication allergy

	Yes	Reaction
Aspirin	☐	
Iodine/Shellfish	☐	
Penicillin	☐	
Sulfa	☐	
	☐	
	☐	
	☐	
	☐	
	☐	

Medication List

❑ Aspirin 81 mg once a day ❑ Aspirin 325 mg once a day ❑ Other Aspirin: _____

Prescription Medication Name	Dose (mg)	Times Each Day

Over-The-Counter Medication Name	Dose (mg)	Times Each Day

CALIFORNIA CARDIOVASCULAR INSTITUTE - CENTRAL COAST

AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I hereby authorize _____
(Name of physician, hospital, or health care provider)

to disclose to:

California Cardiovascular Institute – Central Coast
835 Aerovista Place, Suite 110, San Luis Obispo, CA 93401
Telephone Number (805) 457-9568
Fax Number (805) 457-9569

medical records and information pertaining to medical history, physical condition, services rendered, or treatment of

_____ _____ _____
Patient Name (PRINT) Date of Birth Social Security No.

_____
(Patient Address)

_____
(Patient Telephone Number)

Purpose of Request

_____ Healthcare _____ Insurance Coverage _____ Personal

Records to be disclosed
❑History & Physical ❑Discharge Summary ❑Consultation Notes ❑Cardiac Testing Reports
❑Radiology Reports ❑Laboratory Reports ❑Pathology Reports ❑Operative Reports ❑Any/all records
❑Other _____

From _____ to _____

Neither treatment, payment, enrolment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. This authorization shall become effective immediately and shall remain in effect until _____ or for one year from date of signature.
(Date)

The undersigned may cancel this authorization at any time by submitting a written request to medical records.
I understand that I may inspect or copy the information to be used or disclosed.

Signature of Patient or Legal Representative	*Relationship to Patient*	*Date Signed*

CALIFORNIA CARDIOVASCULAR INSTITUTE - CENTRAL COAST

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and ere committed to maintaining the confidentiality of your health information. We make a record of the health care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality health care, to obtain payment for services provided to you, as permitted by your health plan, and to fulfill our professional and legal obligations to properly operate this medical practice We are required by law to maintain the privacy of protected health information to provide individuals with notice of our legal duties and privacy practices with respect to protecting health information and to notify affected individuals after a breach of unsecured protected health information. This notice describes how we may use and disclose your health Information. it also describes your rights and our legal obligations with respect to your health information If you have any questions about this Notice, please contact our Privacy Officer at (661) 371-2771.

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it In a record, on a computer and in an electronic health record/personal health record, considered your medical record. The medical record is the property of this medical practice, but the Information In the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes;

Treatment - We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

Payment - We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations - We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Officer.

Appointment Reminders - We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign In Sheet - We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and Communication With Family - We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Right to Request Special Privacy Protections - You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision. 2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy - You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to an Accounting of Disclosures - You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization.

Right to a Paper or Electronic Copy of this Notice - You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

Changes to this Notice of Privacy Practices - We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

Complaints – If you have questions or need further clarification, please contact the practice's Privacy Officer at (661) 371-2771. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Department of health and Human Services, Office for Civil Rights, Hubert Humphrey Building, 200 Independence Avenue, SW Room 509F HHH Building, Washington, DC 20201(OCRMail@hhs.gov). The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.