# PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.

A Professional Corporation

## PATIENT INFORMATION

Last Name:______________________________________ First____________________________________ MI_________
Date of Birth: ____________________ SS#_______________________________ Sex: ☐ Male ☐ Female
Address:__________________________________________ City______________________ State_______ Zip_______
Home Phone:_________________________ Work Phone:______________________ Cell:____________________
Employer:__________________________________________ Occupation:____________________________________
Employer Address:_________________________________ City______________________ State_______ Zip_______
Drivers License #:________________________ State______ Expires:__________ Marital Status:_________________
Primary Care Physician:_______________________________________________ Phone:______________________
Referring Physician:__________________________________________________ Phone:______________________
Emergency Contact::__________________________________________________ Phone:______________________

## SPOUSE INFORMATION

Last Name:______________________________________ First____________________________________ MI_________
Address:__________________________________________ City_______________________ State_______ Zip_______
Home Phone:__________________________ Work Phone:______________________ Cell:_____________________

## PRIMARY INSURANCE

Name of Insurer:___________________________________ Insured Name:______________________________________
ID#::____________________________________________ City__________________________ State_______ Zip_______
Insured SS#:____________________________________________ Insured's Date of Birth:____________________________
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other:______________________________

## SECONDARY INSURANCE

Name of Insurer:___________________________________ Insured Name:______________________________________
ID#::____________________________________________ City__________________________ State_______ Zip_______
Insured SS#:____________________________________________ Insured's Date of Birth:____________________________
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other:______________________________

## ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION RELATED TO MEDICAL SERVICES PROVIDED

I hereby assign all benefits to Pacific Cardiovascular Associates Medical Group, Inc. for services rendered to me or said patient. I authorize any holder of medical information about me or said patient to release to my Insurance Company any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to Pacific Cardiovascular Associates and I authorize the release of medical information necessary to pay the claim. I have given all my insurance information for billing purposes and understand the billing procedures. I understand that I am responsible for all charges not covered by my insurance policy including, but not limited to, co-payments, deductibles and non-covered services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if my insurance company does not remit payment on my behalf.

Patient Signature:_______________________________________________________________ Date:____________

If other than patient please state relationship:____________________________________________________________

**(OVER)**

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| PATIENT NAME: | DATE OF BIRTH: | |
|---|---|---|
| PHYSICIAN NAME: | PATIENT ID #: | |
| HEALTH PLAN: | INSURANCE ID#: | EFFECTIVE DATE: |

## ♥ PHOTOGRAPHY CONSENT FORM ♥

**I, ________________________________________, hereby Give ☐ Do Not Give ☐ (please check one)** my consent to have a photograph made of myself in order to document care. I understand that Pacific Cardiovascular Associates will retain the right to this photograph, but that I will be allowed access to view or obtain a copy. I understand that the image will be stored in a secure manner that will protect my privacy and it will be kept for the time period as outlined in PCA's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from my legal representative or myself.

**Note:** This consent does not authorize the use of the images for other purposes, such as teaching or publicity. A separate consent for photography form should be used for such purposes.

______________________________________________ ______________________________

Signature of Patient or Legal Representative Date

______________________________________________ ______________________________

Signature of Witness Date

## ♥ HEALTHCARE ELIGIBILITY WAIVER ♥

The Patient or Patient's Legal Representative hereby certifies that he/she is eligible for health plan benefits coverage, and has chosen the above stated physician as the provider of his/her health care.

Furthermore, the Patient or Patient's Legal Representative understands that if he/she is found ineligible for coverage of plan benefits, he/she is financially responsible for all costs incurred during the delivery of health services, and agrees to pay these charges to the physician accordingly.

______________________________________________ ______________________________

Signature of Patient or Legal Representative Date

______________________________________________ ______________________________

Signature of Witness Date

P · C · A

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# Communication Consent

Name: ______________________________________________________________Date of Birth: __________________________
First Last MI

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (please check all that apply):**

- ☐ **Home Telephone** _________________________
  - ☐ **Leave message with detailed information**
  - ☐ **Leave message with call back number only**
- ☐ **Work Telephone** _____________________________
  - ☐ **Leave message with detailed information**
  - ☐ **Leave message with call back number only**
- ☐ **Written Communication**
  - ☐ **Mail to my home address**
  - ☐ **Mail to my work/office address**
- ☐ **Other:**
  __________________________________________
  __________________________________________

Please add any special instructions regarding the release of your medical information (i.e., specific family member or representative):_____________________________________________________________________________________
______________________________________________________________________________________________

| ________________________________________ | ________________________________________ |
|---|---|
| **Patient's Printed Name** | **Patient's Date of Birth** |
| ________________________________________ | ________________________________________ |
| **Patient's Signature** | **Date** |

***(OVER)***



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# Healthcare Medical Records Request

| PATIENT NAME: | DATE OF BIRTH: |
|---|---|
| ADDRESS: | INSURANCE #: |
| CITY, STATE & ZIP | DATE OF REQUEST: |

I, the undersigned, hereby authorize ______________________________ to provide from my medical record the information specified Health Care Facility/Provider

below to: ***Pacific Cardiovascular Associates Medical Group*** for the purpose of diagnosis and treatment.

**THE FOLLOWING INFORMATION IS REQUESTED:**
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

_________________________________________________
Time period to be covered

This authorization shall be valid until: ___________________

*Release or transfer of the specific information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or its transfer to another person or entity. Thank you for your understanding and cooperation.*

*I understand that I have requested a right to receive a copy of this authorization upon my request.*

*Copy requested and received:* ☐ Yes ☐ No

__________________________________________________ ____________________________
Signature of Patient or Legal Representative Date

__________________________________________________ ____________________________
Signature of Witness Date

☐ **PLEASE FAX MEDICAL RECORDS TO:** ___________________________________________________

☐ **PLEASE MAIL TO:** ________________________________________________________________
________________________________________________________________

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## ♥ PATIENT (SELF) CARDIOVASCULAR HEALTH HISTORY ♥

Name: ____________________________________________________________ Date of Birth: _________________________
First Last MI

Sex: ☐ Male ☐ Female Present or Retired Occupation: _________________________ Marital Status: ______________

Preferred Contact Number: ________________________________________________________________

Current Medical Symptoms / Complaints: ____________________________________________________________________
____________________________________________________________________________________________

List Allergies (Medicines, Foods, Etc.): ____________________________________________________________________
____________________________________________________________________________________________

**Please List all Medications (include dose & how it is taken)**

| MEDICATION | DOSEAGE | HOW/WHEN TAKEN |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| PLEASE LIST MEDICAL OPERATIONS AND DATES |
|---|
| **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |

**FAMILY HISTORY:**
**If family members are living, list health problems and their ages. If deceased, please give age and cause of death.**

| MOTHER | DECEASED | SISTERS | DECEASED | BROTHERS | DECEASED |
|---|---|---|---|---|---|
| | | | | | |
| **FATHER** | **DECEASED** | | | | |
| | | | | | |
| | | | | | |

**If there are close relatives with a history of heart disease, high cholesterol, high blood pressure, stroke, diabetes, cancer, etc., please indicate their relationship, specific medical condition and their age:**
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**SOCIAL HISTORY:**
**Do you Smoke?** ☐ **Yes** ☐ **No** If Yes, how much per day? __________________________
**Have you ever smoked?** ☐ **Yes** ☐ **No** If Yes, for how many years? ________________________
If you stopped smoking, how long ago? _____________ What age did you start? ____________________________
**Do you drink Alcohol?** ☐ **Yes** ☐ **No** If Yes, how many drinks per week? ___________________
**If you stopped drinking, how long ago?** ____________________________________________________________

***(OVER)***

**If you are exercising, please list the type of exercise, frequency, and duration (e.g., walking 3 times per week for 20 minutes):**

_______________________________________________________________________________

_______________________________________________________________________________

**Do you follow a special diet? Yes ☐ No ☐ Low Salt ☐ Low Fat ☐ Low Cholesterol ☐ Other: ☐**

_______________________________________________________________________________

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

| | | | |
|---|---|---|---|
| ☐ **Diabetes** | ☐ **High Blood Pressure** | ☐ **High Cholesterol** | ☐ **Overweight** |
| ☐ **Undue Stress** | ☐ **Previous Heart Attack** | ☐ **Peripheral Vascular Disease** | ☐ **Smoking History** |
| ☐ **Post Menopausal** | ☐ **Prior Bypass Surgery** | ☐ **History of Stroke** | ☐ **Prior Valve Surgery** |
| ☐ **Prior Angioplasty or Stent** | | | |

**If Female, are you still menstruating?** ☐ **Yes** ☐ **No**
**Are you Pregnant?** ☐ **Yes** ☐ **No**
**If No, do you still use Birth Control?** ☐ **Yes** ☐ **No**

**Date of Last Chest X-Ray:** ________________________ **Date of Last EKG:** ________________________

**REVIEW OF SYSTEMS:**

| | | | |
|---|---|---|---|
| Chest Pain at Rest | ☐ Yes | ☐ No | Date Began: __________________ |
| Chest Pain Exercising | ☐ Yes | ☐ No | Date Began: __________________ |
| Palpitations (Heart Pounding, Racing) | ☐ Yes | ☐ No | Date Began: __________________ |
| Short of Breath at Night / Lying Down | ☐ Yes | ☐ No | Date Began: __________________ |
| ☐ At Rest | ☐ Yes | ☐ No | Date Began: __________________ |
| ☐ Exercising | ☐ Yes | ☐ No | Date Began: __________________ |
| Calf / Leg Pain with Ambulation | ☐ Yes | ☐ No | Date Began: __________________ |
| Rheumatic Fever | ☐ Yes | ☐ No | Date Began: __________________ |
| Rheumatic Heart Disease | ☐ Yes | ☐ No | Date Began: __________________ |
| Heart Murmur | ☐ Yes | ☐ No | Date Began: __________________ |
| Swelling of Feet or Ankles (Edema) | ☐ Yes | ☐ No | Date Began: __________________ |
| Congestive Heart Failure | ☐ Yes | ☐ No | Date Began: __________________ |
| Dizziness | ☐ Yes | ☐ No | Date Began: __________________ |
| Fainting | ☐ Yes | ☐ No | Date Began: __________________ |
| Cough with or without Sputum | ☐ Yes | ☐ No | Date Began: __________________ |
| Nausea / Vomiting | ☐ Yes | ☐ No | Date Began: __________________ |
| Bloody or Black Stool | ☐ Yes | ☐ No | Date Began: __________________ |
| Hepatitis or Jaundice | ☐ Yes | ☐ No | Date Began: __________________ |
| Easy Bruising or Bleeding | ☐ Yes | ☐ No | Date Began: __________________ |
| Thyroid Disorder | ☐ Yes | ☐ No | Date Began: __________________ |
| Lung Disease | ☐ Yes | ☐ No | Date Began: __________________ |
| Kidney Disease | ☐ Yes | ☐ No | Date Began: __________________ |
| Headache | ☐ Yes | ☐ No | Date Began: __________________ |
| Leg Cramping | ☐ Yes | ☐ No | Date Began: __________________ |

Patient Signature: ____________________________________________________ Date: ___________

Doctor's Signature: ___________________________________________________ Date: ___________

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# 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.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Angie Scott. Information on contacting us can be found at the end of this Notice.

## TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This discloser involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

***(OVER)***

## HIPAA Notice of Privacy Practices

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

### YOUR PRIVACY RIGHTS AS OUR PATIENT

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $0.25 for each page and the staff time charged will be $10 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2002. Information prior to that date would not have to be released. (*Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosures of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

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### QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding our access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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### HOW TO CONTACT US

Pacific Cardiovascular Associates Medical Group, Inc.
3080 Bristol Street - Suite 600
Costa Mesa, CA 92626
Phone: (714) 445-0220
Fax: (714) 445-0245
Privacy Officer:

Please sign and print your name and provide the date below to acknowledge you have received this Notice of Privacy Practice

______________________________ ______________________________

Print Name Patient's Signature

______________________________

Date