PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
A Professional Corporation

PCA PEDIATRIC PATIENT INFORMATION - CONFIDENTIAL

Patient Last Name:_____ Patient First Name_____MI_____

Date of Birth:_____SS# (last 4) _____Sex (at birth): Male ☐ Female ☐

Parents Email Address: _____

Would you like to be enrolled in our Patient Portal program: Yes ☐ No ☐

Address:_____Apt/Unit:_____

City_____State:_____Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Parents Employer:_____Parents Occupation: _____

Parents Driver's License #:_____State: _____ Expires: _____

Language Preferred:_____Race: _____Ethnicity: _____

Referring Physician/PCP:_____Phone: _____

Emergency Contact:_____ Relation:_____ Phone:_____

Insurance Carrier:_____ID #:_____

Subscriber Name & DOB: _____ Effective Date: _____

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 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.

NOTICE OF PRIVACY PRACTICES

☐I hereby acknowledge that I was offered a copy of PCA's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices to the e-mail above.

P·C·A

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AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

I am the: ☐ Parent

Guardian

Other person having legal custody _____
(Describe legal relationship)

of *(name of minor)* _____, a minor.

I hereby authorize (name of agent) _____, to act as my agent to consent to any x-ray examination, anesthetic, medical, surgical diagnosis or treatment, and hospital care, which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor recommends.

This authorization is given pursuant to the provisions of Family Code Section 6910.

I hereby authorize any hospital providing treatment to the above-named minor pursuant to the provisions of Family Code Section 6910 to surrender physical custody of the minor to the above-named agent upon the completion of treatment. This authorization is given pursuant to Health and Safety Code Section 1283.

This authorization shall remain effective until (*month and day*) _____, 20_____, unless sooner revoked in writing delivered to the agent named above.

Date:_____ Time:_____ AM/PM

Print Name:_____

Signature:_____

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COMMUNICATION CONSENT

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):
Phone (voice message) | **Text Message | Email (please check your spam inbox)**

HIPAA DISCLOSURE INFORMATION

By completing this you are granting permission to someone other than yourself to have access to scheduled appointment times, schedule an appointment and be informed about test results and general information regarding your health.

Do you have any disclosure restrictions regarding appointment details, test results and/or general health information?

☐ **No** ☐ **Yes**

If you marked no, who may we disclose the information to besides yourself?

1. _____ _____
NAME **Relationship**

2. _____ _____
NAME **Relationship**

By signing below, I authorize PCA through its vendors or directly to contact me by SMS text message or email to serve me better. PCA will send me text messages or emails through PCA's outreach partners to help me or my family members provide feedback, remind me of appointments, and remain better connected to the practice. I understand that message/data rates may apply to messages sent through PCA to my cell phone. I know that I am under no obligation to authorize PCA to send me text messages as part of this program. I may opt-out of receiving these communications from PCA at any time by calling PCA at (877-430-7337).

Patient Signature:_____Date:_____

If not signed by the patient, please indicate relationship:
☐ Parent or guardian or minor patient ☐ Guardian or conservator of an incompetent

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. Ensuring the cardiovascular well-being of our patients and their families has been PCA's mission for over 30 years. We strive every day to provide you with the highest quality of care you expect and deserve. Providing you with the **best possible care** requires a "partnership" between you and your physician. To embark on this "partnership in your health" we ask you to help us and we need your agreement to the following. This is not an exhaustive list but highlights a few key areas.

1. **Keep Appointments for Consultation, Follow up or Testing**
   I understand that the appointments for consultation, follow up or testing are very important to initiate and/or execute my treatment plan. During these appointments, my physician might order tests, review my plan of care, prescribe medication, or even discover and treat a serious health condition. If I don't show up for my appointment, or miss my appointment and fail to reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition.

   In addition, I understand that missing or not showing up for my appointment creates a significant hardship for my physician and is not fair for other patients who would like to access cardiology services by my physician's practice. I will make every effort to notify my physician, his or her nurse or the scheduling team a minimal of 48 hours in advance of my appointment cancellation and reschedule missed appointments, as soon as possible.

   If you are unable to make your appointment due to a *bona fide* emergency, no cancellation fee will apply provided you supply written documentation or proof of the emergency. In all other instances a "$50.00 no show cancellation fee" will be charged, without exception, for un-kept appointments not canceled 48 hours before the scheduled appointment time.

2. **Contact the Physician's Office When I Do Not Hear the Results of Labs and Other Tests**
   I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results. If my contact information has changed, I will notify PCA of my updated contact information.

3. **Inform My Physician if I Decide *Not* to Follow His or Her Recommended Treatment Plan**
   I understand that after examining me, my physician may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, ordering tests, performing procedures, referring me to other specialists, ordering lab tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan is my right but can have serious negative effects on my health. I will let my physician know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask. We are here to help you get better and lead active healthy lives.

_____ _____
Patient Name (Print) Date

_____
Patients Signature

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

3080 Bristol Street, Suite 600
Costa Mesa, CA 92626
Fax: (714) 445-0245

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION
I hereby authorize: _____
Healthcare Provider's Name and Address
To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____
Name
_____
Address City State Zip Code
_____
Fax Email
The medical information/records will be used for the following purpose: _____
This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____
I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial) Tests for Antibodies to HIV_____(initial)
Psychiatric/Mental Health _____(initial) HIV Diagnosis/Treatment_____(initial)
Genetic Information _____(initial)

DURATION (Not to exceed 2 years)
This authorization shall be effective immediately and remain in effect until_____Date

*If changing physician practice, please explain why: _____

RESTRICTIONS
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal representative* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness Name (Print) Witness Signature

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♥ PATIENT (SELF) CARDIOVASCULAR HEALTH HISTORY ♥

CONFIDENTIAL

Name:_____ Date of Birth:_____

Current Medical Symptoms / Complaints:

_____

_____

For Vein related symptoms such as — Varicose veins, spider veins, swelling, or pain. (Please inform Nurse)

RISK FACTORS (Please check all that apply):

☐ Pregnant/or could be pregnant

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Overweight

☐ Undue Stress ☐ Previous Heart Attack ☐ Peripheral Vascular Disease ☐ History of stroke

☐ Post-Menopausal ☐ Prior Bypass Surgery ☐ History of stent/angiogram ☐ Prior Valve Surgery

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

MEDICATION	DOSEAGE	HOW/WHEN TAKEN

PLEASE LIST ALL ALLERGIES (Medicines, Foods, Etc.):

_____

PLEASE LIST ALL MAJOR MEDICAL OPERATIONS AND DATES:

_____

_____

FAMILY HISTORY:

Please List all close family 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 Currently? ☐ Yes ☐ No / If Yes, how much per day? _____

•Have you ever smoked? ☐ Yes ☐ No / If Yes, see below

What age did you start smoking? _____ What age did you quit smoking? _____

•Do you drink Alcohol? ☐ Yes ☐ No / If Yes, how many drinks per week? _____

•If you stopped drinking, how long ago? _____

•Do you Drink Caffeine or use prescription or non-prescription stimulant medications? ☐ Yes ☐ No / If Yes, What type?_____ How much per day?_____