Comprehensive Cardiovascular
CCVMG
*Leading the fight against heart disease*

## PATIENT INFORMATION

| NAME (Last, First Middle) | | | MRN | SSN# |
|---|---|---|---|---|
| BIRTH DATE | LANGUAGE | SEX | PHONE NUMBER<br># | CELL PHONE (ANDROID OR IPHONE?)<br># |
| ADDRESS CITY, STATE ZIP | | | | |
| EMAIL ADDRESS | TELEHEALTH PREFERENCE<br>**Facetime Google Duo Zoom Doxy.me Other:** | | | ENROLL ME IN PATIENT PORTAL:<br>**YES / NO** |
| PRIMARY CARE PHYSICIAN | WHO REFERRED YOU? | | | EMERGENCY CONTACT:<br>**Name:**<br>**Phone Number:** |

## PRIMARY INSURANCE

| NAME OF THE INSURANCE COMPANY | POLICY# |
|---|---|
| SUBSCRIBER<br>**SELF SPOUSE PARENT CHILD** | GROUP# |
| ADDRESS CITY, STATE ZIP OF INSURANCE COMPANY | |

## SECONDARY INSURANCE

| NAME OF THE INSURANCE COMPANY | POLICY# |
|---|---|
| SUBSCRIBER<br>**SELF SPOUSE PARENT CHILD** | GROUP# |
| ADDRESS CITY, STATE ZIP OF INSURANCE COMPANY | |

## EMPLOYER INFORMATION

| PRIMARY EMPLOYER | OCCUPATION | WORK PHONE NUMBER<br># |
|---|---|---|
| ADDRESS CITY, STATE ZIPOF EMPLOYER | | |

## RESPONSIBLE PARTY INFORMATION (If Different Than Above)

| NAME (Last, First Middle) | RELATIONSHIP TO PATIENT | BIRTH DATE | LANGUAGE |
|---|---|---|---|
| ADDRESS CITY, STATE ZIP | | | |
| HOME PHONE | SECONDARY HOME PHONE(if applicable) | | |

1. I hereby assign the insurance benefit payment, both basic and major medical to which I am entitled, directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A photocopy of this authorization is accepted with the same authority as the original.
2. I hereby authorize the physician to release any information acquired in the course of my treatment to another physician of my choice, my insurance company, my attorney or to me at the above address within one (1) year of the date of this signature.

**SIGNATURE OF PATIENT/GUARDIAN** _____ **DATE** _____

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5945 Truxtun Extension ▪ Bakersfield, CA 93309

# NEW PATIENT CARDIAC HISTORY QUESTIONNAIRE

| | | |
|---|---|---|
| **Name:** | **DOB:** | **Date:** |
| **Referred by:** | **PCP:** | **Pharmacy:** |
| **Reason for visit:** | **Occupation:** | **Insurance:** |
| **Current Medications:** (Name, dose, Frequency) | | |
| **ALLERGIES:** Iodine Shellfish Aspirin Tape Latex Other | | |

-

- **Heart Attack**
- **Angiogram**
- **Angioplatsy/ STENT**
- **Bypass Surgery**
- **Cardiomyopathy**
- **Heart Failure**
- **Atrial Fibrillation/Flutter**
- **Irregular Heart Beat**
- **Pacemaker**
- **Stroke**
- **Valve Disorder or Replacement**
- **Aneurysms**
- **Peripheral Vascular Disease**

## RISK FACTORS:

- **Tobacco/Smoking**
- **High Cholesterol**
- **Diabetes**
- **Alcohol/Drugs**
- **High Blood Pressure**
- **Family History**

## PRIOR TESTING / PROCEDURES: *(Dates, where done, results if known…)*

| | | | |
|---|---|---|---|
| **Echocardiogram** | **EKG** | **Holter Monitor:** (24 hr EKG) | **Stress Test** |
| **Carotid Ultrasound** | **Lower Extremity Doppler:** | | **Coronary CTA** (CAT Scan) |

## PAST MEDICAL HISTORY:

- **Sleep Apnea**
- **Cancer**
- **Anxiety**
- **Lung Disease**
- **E.D.**
- **Refused Blood Products**
- **GERD:**Reflux/Indigestion
- **Thyroid Dysfunction**
- **Kidney Disease**
- **Bleeding/Transfusions**

## Surgeries / Other? _____


# HIPAA PRIVACY FORM

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment.

**This request supersedes any prior request for confidential channel communications I may have made.**

**Please select all that apply. Where you list more than one communication option, please indicate which you prefer.**

**I want you to contact me by telephone at**_____

Do Do not leave messages on my answering machine.

Do Do not leave messages with any other person (**if yes please designate names below**)

- Spouse (print name) _____
- Child/Children (print name) _____
- Parent/s (print name) _____
- Sibling (print name) _____
- Other (print name) _____

**I want you to contact me at the following address:** _____

_____

**E-Mail Address:** _____

I will be responsible for communicating any changes or new restrictions to your office in writing.

## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You have the right to refuse to sign this Acknowledgement**

I,_____ have received a copy of this office's
(Signature of Patient or Parent/Guardian)

*NOTICE OF PRIVACY PRACTICES* as required by federal law.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Signature of Patient or Parent/Guardian Date

# NOTICE OF PRIVACY PRACTICES

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. *"Protected Health Information" is* information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related services.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:**

Your protected health information will be used, as needed, to obtain payment for your health care-services. For example, obtaining approval for a **hospital** stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:**

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name **in the** waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

**We may use or disclose your protected health information in the following situations with your authorization. These situations included:**

Public health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**You have the right to inspect and copy your protected health information:**

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information:**

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. You request must state the specific restrictions and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to Accept this notice alternatively i.e. electronically.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:**

You have the right to file a complaint with our Secretary of Health and Human Services if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our Compliance officer of you complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person, writing, or by phone at (661) 631-5544 extension 108.

**This notice was published and becomes effective on/or before April 14, 2003.**