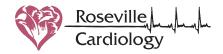


# REGISTRATION FORM (Please Print)

Today's Date		PC	CP			
	PATIENT	INFORMATION				
Patient's Last Name		First		N	Middle	
☐ Mr. ☐ Mrs ☐ Miss. ☐ Ms.	Marital Status:	☐ Single ☐ Mar	□ Div □ Se	ep 🗆 Wid		
Is this your legal name? ☐ Yes ☐	No If not, what is y	our legal name?_				
Former / Maiden Name		Sex 🗆 F 🗆 M	Age	Birth Dat	e/	_/
Street Address		Social Security #		Home Pho	ne	
P.O. Box C	ty		State	7	Zip Code	
Occupation						
Race: □ Caucasian/White □ At	rican American 🛭	Chinese 🗆 Filipin	no 🗌 Japan	ese 🗆 Kore	ean 🗆 Vie	tnamese
☐ Other Pacific Islander ☐ Mexic	can 🗌 Other Span	ish 🗌 Other				
Language: ☐ English ☐ Spanish	☐ Other		Interprete	r Needed: [	□Yes □N	10
	INSURANC	E INFORMA	TION			
(Pleas	se give your insuran	ce card and ID to t	the reception	nist.)		
Responsible Party if Minor Patient_	_				re /	/
Address (if different) Home Phone Guarantor Employer Name Guarantor Employer Phone						
Guarantor Employer Address						
Name of Primary Insurance						
ID / Policy # Group						
☐ Other		_			·	
Name of Secondary Insurance		Sub	scriber Name	e		
ID / Policy # Group						
Other		_				
		OF EMERGEN	NCY			
Name of Local Friend or Relative	not living at same o	address)				
Relationship to Patient	_					
Alternate Contact Person						
Relationship to Patient	Hom	e Phone	V	Vork Phone _		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize <b>Roseville Cardiology</b> or insurance company to release any information required to process my claim(s).  Patient/Guardian Signature						



#### WELCOME TO OUR PRACTICE

This information is provided to assist you in using our services effectively and efficiently.

#### **REGISTRATION**

Upon checking in our office staff will ask you to verify your address, telephone number, and insurance billing information. Please have a copy of your insurance card (s).

#### **APPOINTMENTS**

We see our patients in the office by appointment only. You may call the office between 8:30 and 5:00, Monday through Friday, except holidays. If you feel that your problem represents an EMERGENCY; please identify this for the office staff or with the answering service after hours.

#### **CANCELLATIONS AND NO SHOWS**

If you fail to keep your confirmed appointment for a test procedure without a 24-hour notice to our office, you will be charged \$50.00 for that appointment. Your insurance will not cover this missed appointment. Repeated failure to keep appointments may result in termination of the physician/patient relationship.

#### **BILLING INFORMATION**

Our billing office will process your claims to your insurance company(s). If you do not have insurance, we ask that you prepay for your initial visit and any diagnostic service and pay at the time of your visit for follow-up services. Our patient account representatives are available from 8:30-5:00, Monday through Friday except holidays to answer any billing statement, insurance questions and payment arrangements. Please call (916) 782-2198.

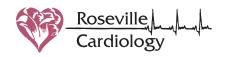
After we bill your health insurance, you will be responsible for the remaining balance after your insurance (s) has paid their portion of the service. Please be sure that you understand the provisions of your insurance plan and what your responsibility is. Insurance coverage, provisions and restrictions are constantly changing. It is ultimately your responsibility to know what is included and excluded in your specific policy. We are not contracted providers for all insurance companies. You will receive a monthly statement stating your current balance. Please note that your payment is requested by the due date listed on the statement.

#### **FORMS COMPLETION**

It is our office policy to charge any request for correspondence such as a letter of medical necessity and disability forms. The form fee is \$15 for the first page and \$5 for each additional page.

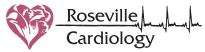
Please read, return and sign this form as an acknowledgement that you are aware of our office policies.

Patient Signature	Date
Printed Name	



## PATIENT HISTORY

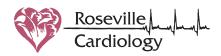
Patient Name				Fan	nily Docto	or	
	MAJOR CO	OMPLAI	NTS			DOCTOR	RS SEEN IN LAST YEAR
1					•		
				2	•		
3				3	•		
<del>-</del>	-		ite (use reverse	=	:		
1							
3.							
4							
5							
Hospitalization	ns (include su	rgeries):					
						When	How Long
Reason						When	How Long
							110W Long
						When	How Long
Allergies:			_				
1						3	
_			n taken in the la	-		3	
10			11				
Date of Last El	(G:			Date o	f Last Che	est X-Ray: _	
FAMILY H	ISTORY		If Living		If De	ceased	Has any blood relative had?
Father		Age	Health	Ag	je	Cause	Heart Trouble □ No □ Yes
Mother Brother or Sister				- 1			High Blood Pressure □ No □ Yes Diabetes □ No □ Yes
]							Diabetes □ No □ Yes Stroke □ No □ Yes
2							Cancer No Yes
3							
4 Spouse							NOTE: This is a confidential record of your health history
Children							and will be kept in this
1							office. Information
2							contained here will not be
3 4							released, unless you authorize us to do so.
5							doi/10/120 03 10 do 30.
							ı
Social History:				F	ducatio-		
Occupation_ Smoking:	Yes N	 Io		E			
Alcohol:	Yes No Packs per day Years smoking Frequency						
Hobbies:	/ 1				- **		
Diet:	□ Regular		abetic	☐ Lowf		Other	
Exercise:	☐ Sedentar	y 🗆 W	alk Frequently 1	10 - 15 mins		Very Activ	re: Regular Workouts/Jogging/Biking



#### PATIENT HISTORY continued Patient Name **GENERAL SKIN CONTINUED** □ Chills □ Rash Depression □ Scars □ Dizziness ☐ Sores that won't heal ☐ Fainting □ Fever EYE, EAR, NOSE, THROAT ☐ Forgetfulness ☐ Bleeding gums ☐ Headache ☐ Blurred vision □ Loss of Sleep □ Difficulty swallowing □ Loss of Weight ☐ Double vision □ Nervousness □ Earache □ Numbness ☐ Ear discharge ☐ Hay fever □ Sweats ☐ Hoarseness MUSCLE/JOINTS/BONE □ Loss of hearing ☐ Pain, weakness ☐ Nosebleeds ☐ Persistent cough ☐ Arms □ Back □ Ringing in ears □ Feet ☐ Sinus problems ☐ Hands ☐ Vision - Flashes ☐ Hips ☐ Vision - Halos □ Legs **NEUROLOGICAL** ☐ Shoulders □ Seizures **GENITO-URINARY** ☐ Weakness of arms or legs ☐ Blood in urine ☐ Trouble with balance ☐ Frequent urination ☐ Tremors □ Lack of bladder control □ Trouble talkina ☐ Painful urination ☐ Memory problems **GASTROINTESTINAL MEN only** ☐ Appetite poor ☐ Breast lump □ Erection difficulty □ Bloating □ Bowel Changes □ Lump in testicles Constipation □ Penis discharge □ Diarrhea ☐ Sore on penis ☐ Excessive hunger □ Other ☐ Excessive Thirst **WOMEN** only □ Gas ☐ Hemorrhoids ☐ Abn Pap smear □ Bleeding between periods Indigestion ☐ Nausea ☐ Breast lump □ Rectal Bleeding ☐ Extreme menstrual pain ☐ Stomach Pain ☐ Hot flashes ☐ Vomiting □ Nipple discharge ☐ Vomiting Blood ☐ Painful intercourse □ Vaginal discharge SKIN Other \_\_\_\_ ☐ Bruise easily

☐ Hives☐ Itching

☐ Change in moles



#### PATIENT PRIVACY FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that, effective April 14, 2003, we provide you a printed copy of the Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgement that you have received this summary. A copy of the full Notice is available upon your request.

#### Your rights as a patient

You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

#### Use of Protected Health Information

We are permitted to use your protected health information for treatment purposes to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as over hearing a conversation that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid, and considers them permissible.

For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes we require that they sign a contract in which they agree to protect the confidentiality of the information.

#### <u>Disclosure of Protected Health Information Requiring Your Authorization</u>

For disclosures that are not related to treatment, payment or operations we will obtain your specific written consent, except as described below.

#### Communications to You of Confidential Information by Alternative Means

If you make a written request, we will communicate confidential information to you by reasonable alternative means or to an alternative address.

#### Restrictions to Use and Disclosure

You may request restrictions to the use of disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

#### Access to Protected Health Information

You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which under specific circumstances, will be reviewed by a third party not involved in the denial.

#### <u>Amendments to Medical Records</u>

You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have the right to dispute such denials and have your objections noted in your medical record.

#### Accounting of Disclosures of Protected Health Information

You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment or operations, and disclosures that were made as a result of your written authorization.

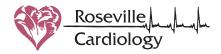
#### Other Uses of Your Health Information

Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

#### How to Lodge a Complaint Related to Perceived Violations of Your Privacy Rights.

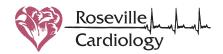
You may register a complaint about any of our privacy practices with our Privacy Officer without fear of retaliation, coercion or intimidation.

Patient Name	
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### ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY OF NOTICE OF PRIVACY PRACTICE

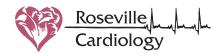
	I acknowledge I have received a cop	oy of this offices' NOTICE OF PRIVAC	CY PRACTICES.
	Patient Signature	Printed Name	Date
	If you are signing as a represe	ntative, documentation for your leg	al right to do so must be provid
	Personal Representative		Date
		Relationship to Patient	
Ackr	nowledgement not obtained because:		
	Patient refused to sign		
	Other		
	/ / Bv:		



# AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL FROM MEDICAL PROVIDERS

I authorize Roseville Cardiology to release any and all medical records concerning my care to any Physician, Hospital or other health care professional providing care to me at any time. I also authorize Roseville Cardiology to release any and all medical record concerning my care to Medicare, Medicaid, any insurance company, third party administrator, or managed care company.

Patient Signature	Date		
D. L. IVI	D 1 (8:11		
Printed Name	Date of Birth		
AUTHORIZATION TO RELEASE			
TO INDIVIDUALS / FA	AMILY MEMBERS		
In accordance with Federal Government privacy ru Portability Act of 1996 (HIPAA), in order for your phys condition with members of your family or other indiv your authorization prior to doing so. In the event of your authorization due to the severity of your medic rules may be waived.	sician or staff of the Practice to discuss your vidual that you designate, we must obtain a critical episode or you are unable to give		
I do not authorize Roseville Cardiology to release any or all information concerning my medical care to any individual except as set forth above.			
I authorize Roseville Cardiology to verbally release any or all information concerning my medical to the following individuals.			
Name	Relationship to Patient		
Name	Relationship to Patient		
Name	Relationship to Patient		
Name	Relationship to Patient		
Patient Signature	Date		
Witness	Date		



## AUTHORIZATION OF RELEASE

PATIENT NAME:	AUTHORIZATION FOR RELEASE		
BIRTHDATE:	OF HEALTH INFORMATION		
FO	R OFFICE USE ONLY		
l authorize:			
	r facility, which has information		
Street Address, City, Sto	ate, and Zip Code		
************	***********************		
Please specify the health information you a	uthorize to be released:		
Type(s) of health information:			
Date(s) of treatment:			
Persons to whom information may be discleding Information described above may be discleding the second seco			
Address & Phone No.			
indicated, the Authorization will expire 12 m release health information is voluntary. Trea conditioned on signing this Authorization ex treatment, (2) to obtain information in conn	expires (insert applicable date of event). If no date is nonths after the date of signing this form. The Authorization to atment, payment, enrollment or eligibility for benefits may not be accept in the following cases: (1) to conduct research-related nection with eligibility or enrollment in a health plan, (3) to an, or (4) to create health information to provide to a third party.		
Printed Name	Signature of patient, or representative		
Date	Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)		