REGISTRATION FORM

(Please Print)

Today's Date______________________ PCP ______________________

PATIENT INFORMATION

Patient's Last Name ______________________ First ______________________ Middle ____________

☐ Mr. ☐ Mrs ☐ Miss. ☐ Ms. Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? ______________________

Former / Maiden Name ______________________ Sex ☐ F ☐ M Age________ Birth Date_____/_____/ ______

Street Address ______________________ Social Security # ____________ Home Phone ______________

P.O. Box______________ City ______________________ State ____________ Zip Code__________

Occupation______________ Employer______________________ Employer Phone No. ______________

Race: ☐ Caucasian/White ☐ African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese

☐ Other Pacific Islander ☐ Mexican ☐ Other Spanish ☐ Other______________________

Language: ☐ English ☐ Spanish ☐ Other ______________________ Interpreter Needed: ☐ Yes ☐ No

INSURANCE INFORMATION

(Please give your insurance card and ID to the receptionist.)

Responsible Party if Minor Patient ______________________ Birth Date_____/_____/ ______

Address (if different) ______________________ Home Phone______________

Guarantor Employer Name ______________________ Guarantor Employer Phone______________

Guarantor Employer Address______________________

Name of Primary Insurance ______________________ Subscriber Name ______________

ID / Policy #______________ Group # ______________ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

☐ Other______________________

Name of Secondary Insurance ______________________ Subscriber Name ______________

ID / Policy #______________ Group # ______________ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

☐ Other______________________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)______________________

Relationship to Patient ______________ Home Phone______________ Work Phone ______________

Alternate Contact Person______________________

Relationship to Patient ______________ Home Phone______________ Work 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 **Roseville Cardiology** or insurance company to release any information required to process my claim(s).

Patient/Guardian Signature______________________ Date______________

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

Roseville Cardiology

PATIENT HISTORY

Patient Name________________________________ Family Doctor ________________________________

MAJOR COMPLAINTS	DOCTORS SEEN IN LAST YEAR
1. ______________________	1. ______________________
2. ______________________	2. ______________________
3. ______________________	3. ______________________

Past History / Major Illnesses and Date (use reverse if needed):

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Hospitalizations (include surgeries):

1. Where ______________________ When __________ How Long __________
   Reason ______________________
2. Where ______________________ When __________ How Long __________
   Reason ______________________
3. Where ______________________ When __________ How Long __________
   Reason ______________________

Allergies:

1. ______________ 2. ______________ 3. ______________

Medications (include all medication taken in the last month):

1. ______________ 2. ______________ 3. ______________
4. ______________ 5. ______________ 6. ______________
7. ______________ 8. ______________ 9. ______________
10. ______________ 11. ______________ 12. ______________

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

FAMILY HISTORY	If Living: Age	If Living: Health	If Deceased: Age	If Deceased: Cause
Father______				
Mother______				
Brother or Sister				
1. ______				
2. ______				
3. ______				
4. ______				
Spouse______				
Children				
1. ______				
2. ______				
3. ______				
4. ______				
5. ______				

Has any blood relative had?

Condition	No	Yes
Heart Trouble	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Cancer	☐ No	☐ Yes

NOTE: This is a confidential record of your health history and will be kept in this office. Information contained here will not be released, unless you authorize us to do so.

Social History:

Occupation______________________ Education______________________

Smoking: Yes______ No______ Packs per day __________ Years smoking __________

Alcohol: Type______________ Amount______________ Frequency __________

Hobbies: ______________________

Diet: ☐ Regular ☐ Diabetic ☐ Lowfat ☐ Other

Exercise: ☐ Sedentary ☐ Walk Frequently 10 - 15 mins ☐ Very Active: Regular Workouts/Jogging/Biking

PATIENT HISTORY continued

Patient Name ________________________________

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINTS/BONE
- ☐ Pain, weakness
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles

SKIN CONTINUED
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

NEUROLOGICAL
- ☐ Seizures
- ☐ Weakness of arms or legs
- ☐ Trouble with balance
- ☐ Tremors
- ☐ Trouble talking
- ☐ Memory problems

MEN only
- ☐ Breast lump
- ☐ Erection difficulty
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other ________________________________

WOMEN only
- ☐ Abn Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other ________________________________

Roseville Cardiology

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.

Disclosure of Protected Health Information Requiring Your Authorization

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.

Amendments to Medical Records

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____

POS Reorder # 1614580

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY OF NOTICE OF PRIVACY PRACTICE

I acknowledge I have received a copy of this offices' NOTICE OF PRIVACY PRACTICES.

_______________________________ _______________________ ____________________

Patient Signature Printed Name Date

If you are signing as a representative, documentation for your legal right to do so must be provided.

_______________________________ ____________________

Personal Representative Date

____ Relationship to Patient

Acknowledgement not obtained because:

☐ Patient refused to sign

☐ Other _____________________________

_____ /_____ /_________ By: ______________________________

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 ______________

Printed Name ______________________ Date of Birth ______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

In accordance with Federal Government privacy rule implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individual that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or you are unable to give your authorization due to the severity of your medical condition the law stipulates that these rules may be waived.

_______ 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**

FOR OFFICE USE ONLY

I authorize: ____

Name of person and/or facility, which has information

____

Street Address, City, State, and Zip Code

****

Please specify the health information you authorize to be released:

Type(s) of health information: ____

Date(s) of treatment: ____

Persons to whom information may be disclosed
Information described above may be disclosed to:

____

Name of Person or Organization

____

Address & Phone No.

Expiration Date of Authorization
Unless otherwise revoked, this Authorization expires __________ (insert applicable date of event). If no date is indicated, the Authorization will expire 12 months after the date of signing this form. The Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine entity's obligation to pay a claim, 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)

Two Medical Plaza, Suite 175, Roseville, CA 95661
Phone (916) 782-2146 Fax (916) 782-9076

POS Reorder # 1614583