Patient Personal Information

___Dr. Haskell ___Dr. Levin ___Dr. Gainer ___Dr. Hunter
___Dr. Bruss ___Dr. O'Bryan ___Dr. Panutich ___Dr. Castellanos

Last Name: ______________________________ First Name:__________________________

Address:____

City/State:__________________________________ Zip Code:________________________

Primary Phone #: ______________________ Secondary Phone #:_______________________

Date of Birth: _______________ Social Security #: ___________________Sex: Male/Female

Marital Status: Single Married Divorced Widowed Separated Domestic Partnership

Email Address: ____

Employment: Employed Retired Disabled Not Employed Self Employed

Employer: _______________________ Phone #: _______________ Ext: _____

Spouse/Guardian Information:

Name: ______________________________ Date of Birth: ____________________________

Social Security #: __________________________ Phone #: ___________________________

Payment Information: __________ I have no insurance

Primary Insurance: _________________ Secondary Insurance: ____________

Policy Holder: _____________________ Policy Holder: _________________

Relationship: ______________________ Relationship: __________________

Referred by: ________________ Primary Care Physician: _______________

Emergency Contact: (someone not living with you)

Name: ______________________________________ Relationship: ____________________

Phone #: _________________________ Alternate Phone #: __________________________

I hereby give authorization for payment of insurance benefits to be made directly to Newport Heart for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I agree to pay all the cost of collection and reasonable attorney fees. I hereby authorize for release of all information necessary to secure the payment benefits.

Signature: ____ Date: _______________

HEALTH QUESTIONNAIRE

Name: __________________________________ DOB: _________________ Date: ________

MEDICAL HISTORY:

	DATE	TYPE	HOSPITAL
Health issues/Illnesses	______	________________	__________________
	______	________________	__________________
	______	________________	__________________
	______	________________	__________________
	______	________________	__________________
Surgeries	______	________________	__________________
	______	________________	__________________
	______	________________	__________________
	______	________________	__________________
Injuries	______	________________	__________________
	______	________________	__________________

Do you have any known allergies ?: ____________________________________

Do you have a history of high blood pressure? ____________________________________

Do you have a history of diabetes? ____________________________________

Do you have a history of high cholesterol? ____________________________________

What was your most recent cholesterol value? ____________________________________

(Continued on next Page)

Name: ___________________________________

HEALTH QUESTIONNAIRE – (Cont.)

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE (at death)	CAUSE
Father	_____	_________	_____	_________
Mother	_____	_________	_____	_________
Siblings	_____	_________	_____	_________
	_____	_________	_____	_________
	_____	_________	_____	_________
	_____	_________	_____	_________
Spouse	_____	_________	_____	_________
Children	_____	_________	_____	_________
	_____	_________	_____	_________
	_____	_________	_____	_________

SOCIAL HISTORY

Birthplace: ____

CIRCLE ONE: Single Married Separated Divorced Widowed

Do you have dependents at home? YES NO If so, how many? ________

Occupation: _________________________

Exercise: Type: ______________________ Frequency_____________________________

Alcoholic beverages: Never Rarely Moderately Daily

Tobacco: Never Smoked Quit-when? ________ Packs/day _____________

Drugs (illicit): None In the past Rarely Frequently

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize NEWPORT HEART MEDICAL GROUP to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize NEWPORT HEART MEDICAL GROUP 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. Additionally, I authorize NEWPORT HEART MEDICAL GROUP to release any and all medical records concerning my care to Medicare, Medi-Cal, any insurance company, third party administrator, or managed Care Company.

____________________________________	____________________________________
Patient Name	Date of Birth
____________________________________	____________________________________
Patient Signature	Date Signed

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with federal government privacy ruled implanted through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff at NEWPORT HEART MEDICAL GROUP to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

*In the event of a critical episode or if you are unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

___________ I do not authorize NEWPORT HEART MEDICAL GROUP to release any or all information concerning my medical care to any individual except as set forth above (*)

___________ I authorize NEWPORT HEART MEDICAL GROUP to verbally release any or all information concerning my medical care to the following individuals:

____________________________________	____________________________________
Name	Relationship
____________________________________	____________________________________
Name	Relationship
____________________________________	____________________________________
Patient Signature	Date Signed

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and Disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is 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:

- Home Telephone: ___________________________________
    _________ Ok to leave a message with details information
    _________ Leave a message with call-back number only

- Work Telephone: ___________________________________
    _________ Ok to leave a message with details information
    _________ Leave a message with call-back number only

- Cell Phone: ____
    _________ Ok to leave a message with details information
    _________ Leave a message with call-back number only

- Written Communication
    _________ Ok to mail to my home address
    _________ Ok to mail to my work/office address
    _________ Ok to fax to this number: _____________________________
    _________ Ok to send an e-mail

- Other: ____

NOTICE OF PRIVARY PRACTICE & FINANCIAL POLICY SIGNATURE

*****PLEASE SEE THE ATTACHED HIPAA FORMS*****

Thank you for understanding the Financial Policy. Please let us know if you have questions or concerns. You can reach the Billing Department at 888-679-3904 of the Office Manager at 949-548-9611.

I have received a copy of the Notice of Privacy Practices and Financial Policy for Newport Heart Medical Group.

______________________________________ ______________________________________
Patient Name Date of Birth

______________________________________ ______________________________________
Patient Signature Date Signed

NEWPORT HEART MEDICAL RECORDS CHARGES

As of August 2, 2010, our office policy regarding medical records, forms, letters, and clearance notes is as follows:

- There is a $25 charge for anything listed below
  - Any form needing to be filled out and signed by your physician
  - Any doctors note/letter
  - Pre-operative clearance forms and dental clearance forms
  - Records released from our office
    - Flat rate of $25 or $0.25 per page
    - Copy of echocardiogram images on CD-$50 charge
- There is no charge to send records to your referring physician or primary care physician.

Please be advised records, forms, and letters will not be released until payment has been received. If you have any questions please ask to speak to a representative in the medical records department.

I hereby acknowledge receipt of the above policy.

______________________________	______________________________
Patient Name	Date of Birth
______________________________	______________________________
Patient Signature	Date Signed

TEST RESULTS POLICY

Unlike other medical offices, when one of our patients has any type of laboratory test, x-ray, or cardiology results pending, it is our office policy to request that the patient call our office for these results. **Do not assume that they are normal** if you have not heard from us. We feel that you should know and if desired, have copies of all tests performed, but that **you** should take responsibility to make sure you know they have been reviewed. If abnormal test results are found, we plan to inform you, however, at times, the results are sent to the wrong physician or to your primary care physician and not to our offices. By your participation in your care and assuring that you know that the tests taken have been received by our office, and reviewed by the physician personally, we can act together as a team to achieve the highest quality health care.

Please sign below so our office is advised that you have been informed and understand it fully.

______________________________	______________________________
Patient Name	Date of Birth
______________________________	______________________________
Patient Signature	Date Signed

APPOINTMENT CANCELLATION POLICY

Newport Heart Medical Group requires a 24 hour cancellation notice for all appointments. There is a $50 charge for any appointment that is not cancelled within this period.

If you have any questions, please speak with the office manager.

FINANCIAL POLICY

Thank you for choosing Newport Heart Medical group as your cardiac care provider. We are committed to your treatment being successful. Please understand that payment of your bill is a considered part of your treatment. The following is a statement of our Financial Policy.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD

Regarding Insurance Billing:

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and / or the guarantor listed on the Patient Information form.

HMO Plans (with which we are contracted): All co-pays must be satisfied at every visit. There can be no exception, due to the contractual and uniform compliance issues with your insurance company. You are responsible for obtaining prior approval with your Medical Group or PCP prior to treatment.

PPO Plans (with which we are contracted): We have agreed to take a discount from your insurance company. Your co-insurance is your responsibility and is due at the time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of pocket deductible or coinsurance amounts.

Medicare: We accept assignment with Medicare. Medicare pays 80% of their allowed amount after you satisfy the yearly deductible. You are responsible for the 20% of Medicare's allowed amount. We will bill your secondary insurance as a courtesy.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual customary rates.

Cash Patients

All services must be paid in full at the time of treatment, unless prior arrangements have been made. There is a 20% discount applied if paid in full at the time of treatment.

Returned Checks

A $25.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.