PATIENT PERSONAL INFORMATION

___Dr. Haskell ___Dr. Levin ___Dr. Gainer ___Dr. Hunter ___Dr. Bruss ___Dr. O'Bryan
___Dr. Panutich ___Dr. Allen Kuo ___ Dr. Gennie Yee

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 #: _____

Insurance Information: _____ I have no insurance
Primary Insurance: _____ Secondary Insurance: _____
Policy Holder: _____ Relationship: _____
Referred by: _____ Primary Care Physician: _____

Payment Information:
Credit Card Number: _____ Expiration Date: _____
Security Code: _____ Name on Card: _____

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: _____ Date of Birth: _____

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? _____ Current Smoker? 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.
This release does not have an expiration date.

_____	_____
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 send an e-mail with details
- ☐ Ok to fax to this number: (_____) _____

☐ **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 or 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

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

NEWPORT HEART MEDICAL RECORDS CHARGES

MEDICAL RECORDS CHARGES:

- For any medical records that are requested FROM Newport Heart, there will be a fee of $0.25 per page OR a flat rate of $25.00.
- There is no charge to send records to your referring physician.
- There will be a $15.00 charge to send records if you are changing physicians.

Effective January 1, 2023, Newport Heart will be instituting an administration fee to cover the costs of all documents and/or forms requested to be completed by our office staff or physicians.

OPTION 1: PAY PER SERVICE		**OPTION 2: PAY ANNUAL FEE**
Patients may pay a **$50.00** fee payable at the time of the requested service for each individual document that is needed throughout the year, to a maximum of $100.00		Patients may pay an annual administration fee of **$75.00** per year to cover **ALL** documents requested during a 12-month interval.
Surgery Clearance	$50.00	
Dental Clearance	$50.00	
Letters (travel, time off, disability, jury duty, or misc.)	$50.00	
DMV Handicap Placard Application	$50.00	
Disability/FMLA Documents	$50.00	
Any Specialty Forms requiring Medical Documentation	$50.00	

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

NOTICE ABOUT OPEN PAYMENTS DATABASE

The Open Payments Program (otherwise known as the Sunshine Act) requires manufacturers of drugs, biologicals, devices, or medical supplies covered by Medicare, Medicaid, or CHIP (Manufacturers) to track and report annually to the Centers for Medicare & Medicaid Services (CMS) certain payments or transfers of value made to physicians, teaching hospitals, and other advanced practice clinicians.
CMS publishes this data in a searchable online database accessible by the general public.

The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Patient Name	Date of Birth
Patient Signature	Date Signed

APPOINTMENT 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. Failure to notify our office for cancelling any new patient appointments will result in a **$100 charge**.

In the Office:

- Schedule an appointment by calling (949) 548-9611. Administrative staff may only schedule routine follow-up exams; all acute problems must be evaluated by a physician or nurse practitioner.
- **NO WALK INS**. Newport Heart Medical Group is open by appointment only and cannot accommodate walk-in patients.
- Schedule same-day appointments for ill visits. When one of our providers reviews messages from patients, it is then determined through triage how soon a patient needs to be seen. Our policy is to try to see patients with urgent care needs within 24 hours.
- Patients who arrive on time are seen at their appointment time. Patients who have arrived on time may be seen ahead of those who arrive late. If you arrive too late, we may need to abbreviate or reschedule your visit.
- Call ahead if you are running late or unable to make your appointment time. We will do all that we can to accommodate your appointment and minimize the need to reschedule your appointment.

FINANCIAL POLICY

We are committed to providing you the best of cardiac care. Copayment and deductible payments are determined by your agreement with your insurance carrier. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for payment. Payment is due upon receipt of a statement from our office.

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.