

## PATIENT PERSONAL INFORMATION

Dr. Haskell    Dr. Levin    Dr. Bruss    Dr. O'Bryan    Dr. Panutich  
 Dr. Allen Kuo    Dr. Gennie Yee    Dr. John Nan

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	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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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? \_\_\_\_\_

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(Continued on next Page)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HEALTH QUESTIONNAIRE – (Cont.)**

**FAMILY HISTORY**

	<b>IF LIVING</b>		<b>IF DECEASED</b>	
	<b>AGE</b>	<b>HEALTH</b>	<b>AGE (at death)</b>	<b>CAUSE</b>
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 PRIVACY 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 \$50.00
- There is no charge to send records to your *referring* physician.
- There will be a \$50.00 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.*

### PLEASE "X" THE OPTION YOU WISH TO CHOOSE

<input type="checkbox"/> <b><u>OPTION 1: PAY PER SERVICE</u></b>  Patients may pay a <b>\$75.00</b> fee payable at the time of the requested service for each individual document that is needed throughout the calendar year, to a <u>maximum of \$150.00</u>  <i>Some examples include:</i> <table style="width: 100%; border: none;"> <tr><td>Surgery Clearance</td><td style="text-align: right;">\$75.00</td></tr> <tr><td>Dental Clearance</td><td style="text-align: right;">\$75.00</td></tr> <tr><td>Letters (travel, time off, disability, jury duty, or misc.)</td><td style="text-align: right;">\$75.00</td></tr> <tr><td>DMV Handicap Placard Application</td><td style="text-align: right;">\$75.00</td></tr> <tr><td>Disability/FMLA Documents</td><td style="text-align: right;">\$75.00</td></tr> <tr><td>Any Specialty Forms requiring Medical Documentation</td><td style="text-align: right;">\$75.00</td></tr> </table>	Surgery Clearance	\$75.00	Dental Clearance	\$75.00	Letters (travel, time off, disability, jury duty, or misc.)	\$75.00	DMV Handicap Placard Application	\$75.00	Disability/FMLA Documents	\$75.00	Any Specialty Forms requiring Medical Documentation	\$75.00	<input type="checkbox"/> <b><u>OPTION 2: PAY ANNUAL FEE</u></b>  Patients may pay an annual administration fee of <b>\$100.00</b> per calendar year to cover <b><u>ALL</u></b> documents requested.
Surgery Clearance	\$75.00												
Dental Clearance	\$75.00												
Letters (travel, time off, disability, jury duty, or misc.)	\$75.00												
DMV Handicap Placard Application	\$75.00												
Disability/FMLA Documents	\$75.00												
Any Specialty Forms requiring Medical Documentation	\$75.00												

*(Please note that both options will be applied towards the calendar year, which begins on January 1 and ends on December 31)*

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 **for the 2026 calendar year.**

_____	_____
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 \$50.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.