COASTAL HEART MEDICAL GROUP

Designed for patients with cardiac and vascular conditions

Coastal Heart Medical Group, Inc.
2621 S. Bristol St., #108,
Santa Ana, CA 92704 . Office: (714) 754-1684
12665 Garden Grove Blvd., #203,
Garden Grove, CA 92843 . Office: (714) 638-2042
Fax: (714) 966-0417

PATIENT REGISTRATION FORM

Please give all your insurance cards to receptionist for copying

Name: _____ Date: _____
Last First M. I.

Address: _____
Street City State ZIP

Home Phone _____ Cell _____ Work _____

SS# _____ DOB _____ Email _____

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Referred by: _____ Primary Care Physician: _____

Emergency Contact Information: ***IT IS MANDATORY TO HAVE A SECOND CONTACT ON FILE***

Name: _____ Relationship: _____

Phone: _____ Alternate #: _____

Pharmacy Information We must have this information in order to send prescriptions electronically

Primary Pharmacy _____

Secondary Pharmacy _____

Authorization to file/release information: I hereby authorize Coastal Heart Medical Group, Inc. to release any information to my insurance company, third party payers, or its agents for completion of insurance claims and determination of benefits.

Medical Record Release: My signature below also authorized Coastal Heart Medical Group, Inc. to obtain any & all pertinent medical records on my behalf for my continued medical care.

Medicare Patient's signature: I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries, carriers, or to the Professional Standards Review Organizations.

Assignment of Benefits: I assign payment directly to Coastal Heart Medical Group, Inc. for all medical and or surgical services provided to me by Coastal Heart and its affiliates. A copy of this authorization & assignment is to be considered valid as an original.

Eligibility Waiver: The patient and or legal representative hereby certifies that he or she is eligible for health plan benefits, coverage & has chosen the above stated physician as the provider of his/her healthcare. Furthermore the patient or the patient's legal representative understands that if he/she is found ineligible for the coverage of plan benefits he or she is financially responsible for all costs incurred during the delivery of services rendered & agrees to pay these charges to physician accordingly.

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT.

Signature of patient or legal rep _____ Date _____

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MEDICAL HISTORY FORM

Please fill out this form completely, to the best of your ability

HAVE YOU HAD: (PLEASE "X" EACH LINE IF THE ANSWER IS "YES" LEAVE BLANK IF THE ANSWER IS "NO")

- ☐ HEART PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ CIRCULATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ HEPATITIS
- ☐ DIABETES
- ☐ ALLERGIES/HAY FEVER
- ☐ SHORTNESS OF BREATH
- ☐ ALCOHOL/DRUG ABUSE
- ☐ SCARLET FEVER
- ☐ TONSILS REMOVED
- ☐ EPILEPSY
- ☐ KIDNEY PROBLEMS
- ☐ NERVOUSNESS
- ☐ TUBERCULOSIS
- ☐ EXCESSIVE BLEEDING
- ☐ ULCERS
- ☐ LIVER PROBLEMS
- ☐ GALL BLADDER PROBLEMS
- ☐ CEREBRAL PALSY
- ☐ VENEREAL DISEASE
- ☐ MALIGNANCIES
- ☐ ASTHMA
- ☐ CHRONIC SINUSITIS
- ☐ CHRONIC EAR PROBLEMS
- ☐ ANEMIA
- ☐ CHRONIC FATIGUE
- ☐ DIZZINESS/FAINTING
- ☐ ARTHRITIS/GOUT
- ☐ A.I.D.S.
- ☐ RADIATION

OTHER HEALTH COMPLICATIONS NOT LISTED ABOVE:_____

_____

DRUG ALLERIES:_____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU FEEL THE DOCTOR SHOULD BE AWARE OF: _____

_____

HAVE YOU EVER BEEN HOSPITALIZED? ☐ YES OR ☐ NO IF YES, PLEASE EXPLAIN:

_____

_____

IMMUNIZATIONS (PLEASE ENTER APPROXIMATE DATE AFTER EACH LISTING)

MUMPS _____ RUBELLA _____ PERTUSSIS PNEUMONIA _____ TYPHOID _____

MEASLES _____ FLU _____ POLIO _____ TETANUS _____ DIPTHERIA _____

Are you pregnant? _____ If so, how far along? _____

_____ _____

Signature of patient Date

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REQUEST FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE : _____

_____

_____

To release copies of all medical records obtained during office visits and/ or hospital admissions:

Patient: _____ DOB: _____/_____/_____

Release medical records to: Coastal Heart Medical Group, Inc.

Purpose or need for information: To continue medical care/ treatment

This consent will expire (90) days after the date below.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

Date:: _____/_____/_____ Signature:_____

Witness:_____

FOR OFFICE USE ONLY:

1. All cardiac reports (Diagnostic reports) Other:
2. Operative reports
3. Labs
4. Consult Reports
5. Progress Notes

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information may be used and disclosed and how you can access this information. Please review it carefully.

This notice is effective from 11/14/2017 until further notice.

Right to notice: As a patient you have the right to an adequate notice of the use and disclosure of your protected health information. Under the HIPPA (Health Insurance Portability and Accessibility Act), Coastal Heart Medical Group, Inc. may use your protected health information for treatment, payment and health care. A) Treatment-We may use or disclose your health information to a physician or health provider for treatment. B) Payment-We may use and disclose your health information to obtain payment for services rendered. C) Health care operations-We may use and disclose your health information in connection with our healthcare operations, healthcare operations include quality of assessment and improvement activities, reviewing competence or qualifications of healthcare professionals, evaluating developmental services of medical or training programs and accreditation, certification, licensing and credentialing activities

Authorization: Most use and disclosures that are not in treatment, payment or health care operations require your written authorization. Once signed you may revoke your authorization (written) through our office at any time. We will not ask for special permission.

Emergencies: In a situation of incapacity or emergency, we will give your health information to a member of the family, or other responsible party for your care, using our professional ethics. We will only disclose health information that is directly related to the participation of the person in your care.

Marketing: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may also use or disclose your health information when required to do so by law.

Abuse or Neglect: We may disclose your information to appropriate authorities if we believe you are a possible victim of abuse, neglect, domestic violence or victims of other crimes. We may disclose health information to the extent necessary to notice a serious health threat to health or safety of others.

National Security: We may disclose your health information to armed forces personnel, military authorities under certain circumstances. We may disclose your health information to authorized federal officials for lawful intelligence, counter intelligence and other national security activities. We may disclose health information of inmates or patients to the above mentioned under the respective circumstances.

Appointment Reminders: We may disclose your health information for appointment reminders via phone, fax, email or letters.

Conduct of the office: The staff will say your name aloud to identify and to address the patient correctly and appropriately.

Patient Right: You have the right to restrict the disclosure or use of protected health information (in writing). The restriction request may be denied if the information is required for treatment, payment or health care operations. You have the right to receive confidential communications regarding your protected health information. You have the right to inspect and copy your health information. You have the right to amend your protected health information. You have the right to receive and accounting of disclosures or use of your health information. You have the right to a paper copy of this notice of privacy practices.

Legal Requirements: Coastal Heart Medical Group requires by law to maintain the privacy of your protected health information. We are required to comply with the terms of this notice, as it is currently stated, and reserves the right to change this notice. The policies in any new notice will not be in force until they are published on this site, or are available at our office.

Complaints: If you have complaints about the way your health information was handled, you may file a written complaint to our office. You will not be retaliated against in any way for filing a complaint.

Contact: For more information about the privacy policies of Coastal Heart Medical Group, Inc. please contact our office at the following address or phone number: Coastal Heart Medical Group, Inc. 2621 S. Bristol St, Ste 108, Santa Ana, Ca 92704 (714)754-1684 or email coastalheart.org.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been made aware of the use and handling of my confidential information, and for whom, and where it is used. I also understand I am entitled to a copy of a further detailed notice.

I have been offered a copy of the notice of privacy practices.

_____
Name of patient (please print)

_____
Signature of patient Date

(Signature of patient representative if patient is unable to sign or is a minor)
*Note: The practice reserves the right to modify the privacy practices outlined in this notice.

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

An attempt was made to obtain an acknowledgement on _____.

The acknowledgement was not obtain because:

___ The patient was undergoing emergency treatment.

___ The patient declined to sign the acknowledgement.

___ Other:_____

_____
Name if patient (please print)

_____
Signature of patient Date

(Signature of patient representative if patient is unable to sign or is a minor)

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***THIS SURVEY CONTAINS QUESTIONS CONCERNING VENOUS INSUFFICIENCY IN THE LEG AND ITS SYMPTOMS. PLEASE FILL OUT THIS FORM TO BETTER ASSIST US IN EVALUATING AND TREATING THESE SYMPTOMS, IF PRESENT**

Please put a check by those symptoms that may apply to you.

ATTRIBUTES	YES	NO	IF YES, PLEASE SPECIFY TIME AND FREQUENCY.
Aching/Pain/cramps in legs	☐	☐	
Swollen legs	☐	☐	
Discoloration in legs	☐	☐	
Varicose veins	☐	☐	
Restless legs	☐	☐	
Open wound on legs	☐	☐	
Weak legs	☐	☐	
Dry/ itchy skin	☐	☐	
Heaviness/tiredness	☐	☐	
Burning/numbness and tingling	☐	☐	
Have you tried compression stockings?	☐	☐	
Do you elevate your feet?	☐	☐	

Signature of Patient _____ Date _____

Print Patient Name _____

FOR OFFICE USE ONLY

C.E.A.P. Class _____

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that his agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under the contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment of summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date of notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedures provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:**
Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provisions of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: COASTAL HEART MEDICAL GROUP, INC.
Physician or Medical Group

By:_____
Patient's or Patient Representative's Signature

_____
Date

By:_____
Print Patient's Name

PRINT SAVE EMAIL RESET