Regional Heart Center Cardiology
2220 Lynn Rd., Suite 208
Thousand Oaks, CA 91362
(805) 480-2600
(805) 480-2677 fax

New Patient Packet Instructions:

Welcome to Regional Heart Center Cardiology,

Please print and complete the attached pages. Bring the completed New Patient Packet to your scheduled appointment date and time of _____. Please do not arrive earlier than when you have been scheduled.

Please make sure you have read and understand out **Notice of Privacy** form which is attached.

We also ask that you obtain and bring to the appointment your most recent lab work, physician office notes, any prior cardiac testing from your primary care physician or previous cardiologist, if applicable.

We look forward to meeting you and helping in any way we can.

Thank you,

Regional Heart Center Cardiology

Regional Heart Center Cardiology
2220 Lynn Rd., Suite 208, Thousand Oaks, CA 91360
(805)494-9494 or (805)480-2600

Today's Date_____

First Name:_____ MI:_____ Last:_____

Preferred Name:_____ Marital Status: M_ S_____ D_____ W_____

Date of Birth:_____ Sex:_____ Gender Identity:_ Home:_____

Address:_____ Cell:_____

_____ Work:_____

_____
City State Zip

Employed:_____ Retired:_____ Other:_ Employer:_____

Email:_____

Primary Care Physician:_____ Phone:_____

Primary Care address:_____

Insurance Information (please provide insurance cards to receptionist)

Commercial _____ Medicare_____ Work Comp_____ Other_____

Insurance Comp:_____ Insured/Card holder name:_____

Member ID/Policy#:_____ Group#:_____ Phone#:_____

Secondary Insurance Information (please provide copy to receptionist)

Commercial _____ Medicare_____ Work Comp_____ Other_____

Insurance Comp:_____ Insured/Card holder name:_____

Member ID/Policy#:_____ Group#:_____ Phone#:_____

Emergency Contact:

First, Last Name:_____ Relationships:_____

Hone #:_____ Cell#:_____

Spouse/Guarantor/Responsible Party:

First, Last Name:_____ Relationship:_____

Home#:_____ Cell#:_____

Authorization to pay benefits: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, If any, otherwise payable to me for his/her services as described. Realizing I am responsible to pay non-covered services.

_____

Signature (patient or parent if minor) Date

Authorization to release information: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____

Signature (patient or parent if minor) Date

Patient Intake Questions

Please answer the following questions and email them back as soon as possible (**at least 48 hours before appointment**). This information needs to be documented in your chart prior to your appointment with the doctor.

Patient Name: _____

1. Who is your Primary Care Physician? (If not local, please list their name, phone number and address)

2. What pharmacy do you go to? (You may list both retail and mail order if you use both)

3. Are you allergic to any medications? If so, please list below.

4. Have you recently been hospitalized? If so, for what reason? Which hospital and what dates were you there?

5. Do you smoke?

AGREEMENT

I understand that the information that I have been given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in medical status. I have received this practice's Notice of Privacy Practice written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be needed by this practice, my individual rights and the practice legal duties with respect to my PHI.

I hereby authorize the physician whose name is checked above to furnish information to insurance carriers concerning my diagnosis and treatment and I hereby assign to the physician all payments for the services rendered to myself or my dependents. I understand that all professional services rendered are charges to the patient. Necessary forms will be completed to expedite insurance payments. I understand that I am responsible to pay any amounts not covered by my insurance.

_____ _____

Patient Signature (parent if under 18) Date Witness

ADDITIONAL DISCLOSURE AUTHORITY

May we discuss your treatment with:

Entire Immediate Family	Yes	No
Spouse Only	Yes	No
Other_____	Yes	No

FINANCIAL POLICY

We will gladly submit your Health Insurance claims and ask that you pay your copayment portion at the time of your visit.

Filing insurance claims is a service we provide without charge and in no way relieves you of financial responsibility for your bill.

THERE WILL BE A $50 CHARGE FOR ALL BROKEN APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR TO YOUR APPOINTMENT

_____

Signature Today's Date

TO OUR MEDICARE PATIENTS

As a result of a congressional ruling which was passed into law you may not submit your own Medicare healthcare claims. As a result of this law, Medicare requires that claims be submitted electronically to the Center for Medicare Services (CMS). CMS/Medicare requests your signature on the following statements.

Patient Name:_____
Please Print

I authorize any holder of medical information to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Patient Signature_____ Date_____

FOR YOUR SUPPLEMENTAL INSURANCE CARRIER

I request that the payment of authorized Medicare Supplemental benefits be made to the doctor on my behalf.

_____ Dr. Michael N. Papanicolaou _____ Dr. Christopher M. Purmer

For any services furnished to me. I authorize any holder of medical information, or information needed to determine these benefits, to be released to my supplemental insurance carrier, or to the benefits payable department for related services.

Patient Signature_____ Date_____

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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron 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 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 if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate 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 this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti 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 Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or 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 once proceeding. A claim shall be waived and forever barred if (1) on the date 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 Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or 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 Effective as of the date of first medical services.

Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of 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 ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's (Date)

By: _____
Signature Print Patient's Name

_____
Print or Stamp Name of Physician,
Medical Group or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

NOTICE OF PRIVACY PATIENTS

This notice describes how health and information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information.

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information.

To public health authorities and health oversight agencies that are authorized by law to collect information.

Lawsuits and similar proceedings in response to a court or administrative order.

If required to do so by a law enforcement official.

When necessary to reduce or prevent a serious threat to your health and safety or to a person or organization able to help prevent the threat.

If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

To federal officials for the intelligence and national security activities authorized by law.

To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

For Workers Compensation and similar groups.

Your rights regarding your health Information:

Communications-You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask the we contact you at home, rather than work. We will accommodate reasonable requests.

You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information only to certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Regional Heart Center Cardiology, 2220 Lynn Rd., Suite 201, Thousand Oaks, CA 91362.**

You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Regional Heart Center Cardiology, 2220 Lynn Rd., Suite 201, Thousand Oaks, CA 91362.** You must provide us with a reason that supports your request for amendment.

Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with your practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Regional Heart Center Cardiology at (805)480-2600. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice of our health information privacy policies, please contact **Regional Heart Center Cardiology, 2220 Lynn Rd., Suite 201, Thousand Oaks, CA 91362, telephone (805)480-2600.**

I hereby acknowledge that I have been presented with a copy of **Regional Heart Center Cardiology**, Notice of Privacy Practices.

Print Patient Name:_____

Patient Signature:_____ Date: _____

Patient Name Date DOB

Please complete the Medication List—Update List Regularly

Name of RX	Dose	How Often	Prescribed by Who	What is it for	Side Effects