Patient Registration Form
(Patients over 8 yrs old)

SECTION I – PERSONAL INFORMATION

Patient Name: ____ Date: _______________
Last Middle First

Date of Birth: ____________________ ❑ Male ❑ Female Social Security#________________

Address: ____
Street City State Zip

Home Phone #: ___________________ Email: _____________________ Cell#: _______________

Mother's Name: __________________ Social Security #: _____________ Cell Phone #: __________

Father's Name: ___________________ Social Security #: _____________ Cell Phone #: __________

Emergency Contact: ________________ Relationship: ________________ Ph#: ________________

Primary Physician: ______________________ City: ______________ Ph#: ________________
(If the physician who referred you is different from your primary physician, please tell us who referred you.)

Referring Physician: _____________________ City: ______________ Ph#: __________________

Preferred Pharmacy: ______________________

How did you hear about us? ____

SECTION II – INSURANCE ACCOUNT INFORMATION

Primary Insurance: _____________________

Subscriber Name: ______________________

Subscriber Birthday: ____________________

Subscriber's Employer: __________________

Social Security #: _______________________

Relation to patient: _____________________

Insurance ID #: _________________________

Group #: ____________________________

Secondary Insurance: ___________________

Subscriber Name: ______________________

Subscriber Birthday: ____________________

Subscriber's Employer: __________________

Social Security #: _______________________

Relation to patient: _____________________

Insurance ID #: _________________________

Group #: ____________________________

SECTION III – MEDICAL HISTORY

Past Medical History

Reason for today's visit: ____________________

Allergies? ❑ No ❑ Yes Age when diagnosed: ____________ Seasonal? ❑ Yes ❑ No

Severity: ❑ Mild ❑ Moderate ❑ Severe

Drug allergies: ❑ No ❑ Yes: ____________________

Asthma? ❑ No ❑ Yes Age when diagnosed: __________ Ever Hospitalized? ❑ Yes ❑ No

Severity: ❑ Mild ❑ Moderate ❑ Severe

Inhaler? ❑ No ❑ Yes Aerochamber with inhaler? ❑ Yes ❑ No

Frequent Ear Infections? ❑ No ❑ Yes - Age when started: ____________ Tubes? ❑ Yes ❑ No

Is patient currently taking medications? ❑ No ❑ Yes: ____________________

For patients 13 and older: Does your child smoke? ❑ No ❑ Yes

Surgical History

Any surgeries? ❑ No ❑ Yes - explain: ____________________

Age when performed or year________________

Social History

Are parents? ❑ Married ❑ Divorced Is child: ❑ Foster Care ❑ Adopted

Who does child live with? ________________ Grade: __________ School: ____________

Sports/ Clubs: ________________ Hobbies/ Activities: ____________________

Has your child ever…

Passed out DURING exercise, emotion, or startle? .... ❑ Yes ❑ No

Passed out AFTER exercise? .... ❑ Yes ❑ No

Had extreme fatigue associated with exercise (different from peers)? .... ❑ Yes ❑ No

Had unusual or extreme shortness of breath during exercise? .... ❑ Yes ❑ No

Had discomfort, pain or pressure in his/her chest during exercise or complained of his/ her heart "racing or skipping beats?" .... ❑ Yes ❑ No

Had a doctor identify: ❑ High Blood Pressure ❑ High Cholesterol ❑ Heart Murmur ❑ Heart Infection

Had a test ordered by a doctor on their heart? .... ❑ Yes ❑ No

If so, what tests were ordered? ____________________

Been diagnosed with an unexplained seizure disorder or exercise-induced asthma? .... ❑ Yes ❑ No

Used cocaine or strong stimulants more than once? .... ❑ Yes ❑ No

Heart of the Valley
Pediatric Cardiology

SECTION IV – FAMILY HISTORY

Any history of heart disease, high cholesterol, high blood pressure, or heart attack?

❑ Mother – explain: ____________________

❑ Father – explain: ____________________

❑ Maternal Grandparents – explain: ____________________

❑ Paternal Grandparents – explain: ____________________

Any other health issues (ie diabetes, cancer, etc)? ❑ No ❑ Yes - explain: ____________________

Brothers: _________ Health issues? ❑ No ❑ Yes - explain: ____________________

Sisters: _________ Health issues? ❑ No ❑ Yes - explain: ____________________

Has any family member…

Had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning, or others)? .... ❑ Yes ❑ No

Died suddenly of "heart problems" before age 50? .... ❑ Yes ❑ No

Had unexplained fainting or seizures? .... ❑ Yes ❑ No

Been identified with certain conditions such as:

- Hypertrophic cardiomyopathy (HCM) .... ❑ Yes ❑ No
- Dilated cardiomyopathy (DCM) .... ❑ Yes ❑ No
- Aortic rupture or Marfan syndrome .... ❑ Yes ❑ No
- Coronary artery atherosclerotic disease .... ❑ Yes ❑ No
- Heart attack, age 50 years or younger .... ❑ Yes ❑ No

Arrhythmogenic right ventricular cardiomyopathy .... ❑ Yes ❑ No

Catecholaminergic polymorphic ventricular tachycardia .... ❑ Yes ❑ No

❑ Long QT syndrome, ❑ Short QT syndrome, ❑ Brugada syndrome

Pacemaker or implanted cardiac defibrillator .... ❑ Yes ❑ No

Primary pulmonary hypertension .... ❑ Yes ❑ No

Congential deafness (deaf at birth) .... ❑ Yes ❑ No

ALL OF THE INFORMATION BELOW MUST BE READ, COMPLETED AND SIGNED IN ORDER FOR THE DOCTOR TO SEE YOU

PAYMENT POLICY:
Balances are due within 30 days. CO PAYMEN'T'S ARE DUE AT THE TIME OF SERVICE. Patients with HMO's and PPO's of which we contract, will be responsible for co pay amounts and deductibles provided all pre authorizations have been obtained. A $10.00 administrative fee will be added to all copayments not paid on the day of service. It is the responsibility of the patient to maintain and verify eligibility with all state funded or private insurance companies. HMO and PPO patients will be held financially responsible for all charges incurred which are not authorized, not a covered benefit, or determined to be not medically necessary or experimental. It is the responsibility of the patient to appeal these charges with the insurance company. A $200.00 fee will be charged for missed appointments not cancelled within (48) forty-eight hours prior to the scheduled appointment.

Heart of the Valley Pediatric Cardiology (HOTV) requires that a portion of the amount owed will be collected in advance. Copayments and one half any deductible are due at the time of service.

All payments are due at time of service. All payments that are not paid in full within 90 days will be referred to collections.

Other Important Financial Policies:

1) Patients with HMO's and PPO's with which we contract should only be ultimately responsible for co-payment and deductibles provided all information provided by the responsible party is accurate and any required pre-authorizations have been obtained prior to treatment. Patients with an HMO will be held financially responsible for all charges incurred which are not pre-authorized.

2) Even though HOTV will do its best to pre-verify eligibility, it is still the responsibility of the responsible party to maintain and verify eligibility with insurance companies, regardless of whether one has public (MediCal etc) or private insurance.

3) There is a $35 charge for all returned checks. ___________ **Initials**

4) A $10.00 administrative fee will be added to all copayments not paid on the day of service. ___________ **Initials**

5) **A $200.00 fee for ALL patients will be charged for missed appointments not cancelled within (48) forty-eight hours prior to the scheduled appointment. PLEASE NOTE: WE DO CONDUCT COURTESY CALLS PRIOR TO YOUR APPOINTMENT; HOWEVER IT IS NOT OUR RESPONSIBILITY TO REMIND YOU. We will call your home and, if available, cell phone to remind you of the upcoming appointment. ___________ Initials**

6) If your appointment is scheduled for a Monday, cancellations need to be made by Friday at noon. If cancellations are not made by Friday at noon, the cancellation fee of $200 will be charged. ___________ **Initials**

7) Blood pressure monitors that are given out will require a $75 deposit that will be returned when monitor is returned. For any monitors that are not returned to us, you will be charged a fee of $150. Insurance does not cover the deposit for the monitors. ___________**Initials**

8) For any spacers given out, there will be a fee of $20. For any peak flow meters given out, there will be a fee of $20. Insurance does not cover these. __________**Initials**

9) Visit our website or ask us for a complete explanation of our Payment Policies.

Signature: ______________________________________ Date: ________________

UNDERSTANDING, ASSIGNMENT AND RELEASE:

I have read and understand the payment policy. I authorize direct payment of medical benefits to Heart of the Valley Pediatric Cardiology and authorize the release of any information from any entity in order to process this claim. I understand this assignment will stay in effect as long as the patient remains in this practice.

A late fee of Ten dollars ($10.00) per month will be assessed on any outstanding balances exceeding 30 days. In addition to the late fee if the account is sent to a collection agency a processing fee will be assessed separately from the collection agency's fees.

I understand that I must submit a current and valid insurance card in order to have the insurance company billed directly. I understand that if I fail to submit a valid and current insurance card or if I fail to provide a valid secondary insurance card I will be billed at the non-contracted rate for services payable within 30 days. I understand that I will be held financially responsible for any and all unpaid balance exceeding 30 days. I understand that any insurance disputes will be settled between the insurance company and myself and any unpaid balance will be due and payable to Heart of the Valley upon receipt. Self-pay accounts are due at time of service. Notice to consumers: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322 www.mbc.ca.gov

Signature of Parent/Guardian:________________________________ Date:__________

Please Print Name of Parent/Guardian:____________________________

PAYMENT POLICY: (REQUIRED FOR REGISTRATION)

Balances are due within 30 days. Heart of the Valley Pediatric Cardiology will bill the insurance company first. If you owe a balance our billing department will send you a statement. There will be a thirty-five dollar **($35.00)** charge for all returned checks. Co-payments are due at the time of service. A ten dollar **($10.00**) administrative fee will be added to all copays not paid on the day of service. It is the responsibility of the patient to maintain and verify eligibility with all state funded or private insurance companies. When you receive our statement you can send us a check or call our billing office and request for your outstanding balance to be charged to your credit card. If you do not pay your outstanding balance within 30 days we will automatically charge your credit card for the balance due. __________ **Initials**

HMO and PPO patients will be held financially responsible for all charges incurred which are not authorized, not a covered benefit, or determined to be not medically necessary or experimental. It is the responsibility of the patient to appeal these charges with the insurance company.

A late fee of Ten dollars ($10.00) per month will be assessed on any outstanding balances exceeding 30 days. A $200.00 fee will be charged for missed appointments not cancelled within (24) twenty-four hours prior to the scheduled appointment. In addition to the late fee if the account is sent to a collection agency a processing fee will be assessed separately from the collection agency's fees. __________ **Initials**

I agree to pay for charges that are not covered by my children's insurance. I understand that it is my responsibility to confirm insurance plan's coverage and benefits prior to having services rendered**.**

Signature_____________________________ **Relationship** ____________________________**Date**___________________

I authorize **Heart of the Valley Pediatric Cardiology** to process credit card payment for any outstanding balances exceeding 30 days. Self-pay accounts are due at time of service.

Please Circle the type of card VISA MasterCard Discover or American Express

Credit Card Account Number: ____

Expiration Date: ____________________ 3 Digit Security Code on back of card: _______________

Name on Credit Card: ____

Zip code for billing address: ______________

Signature: ____

Name of Child:____Date:________________________

Consent for Purpose of Treatment. Payment and Healthcare Operations
(HIPAA Patient Consent Form)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Right section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to all of those restrictions, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient or Representative understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to all of the restrictions requested.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I read and understand the above. I consent to the use or disclosure of my protected health information by Heart of the Valley Pediatric Cardiology for the purpose of diagnosing or providing treatment to me or of obtaining payment for my health care bills. I understand that diagnosis or treatment may be carried out only after this consent is signed. In addition, I understand that my "protected health information" means health information, including my demographic information, collected from me and received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. I also understand that postcards addressed to me may be mailed as follow-up reminders. I also understand that I may choose to receive "Electronic Protected Health Information" (ePHI) via an alternate form of communication via email if I provide an email address.

____ ____________________

(Signature of patient or representative) **(Date)**

Medical Health Information/ Record Permissions:

- Do we have permission to leave a message on your answering machine at home? ☐ Yes ☐ No
- Do we have permission to leave a message at your place of employment? ☐ Yes ☐ No
- With whom can we discuss your/ your child's medical condition? ________________________

  ____
- Who has your permission to request medical records? __________________________________

  ____

Patient Portal Authorization Form

By signing this document I agree to abide by the ethical and legal responsibility to protect the confidentiality of health records. I agree to use the patient portal only to access my own health records, and/or those of my own minor children or those for whom I am the durable power of attorney for health care. If I become aware of a breach of this confidentiality, for whatever reason, I will report it to Heart of the Valley immediately.

Further, I acknowledge that this portal is intended as a convenient service, and not a replacement for in-person health care. I understand that it is inappropriate and dangerous to use this portal for emergency diagnosis for treatment. For non-emergent issues, if I do not receive a response within the expected time-frame, I agree to contact Heart of the Valley by conventional means, such as by phone or in person.

Should I, for whatever reason, gain access to another person's health records, I agree to not read such information and I agree to report the problem immediately to Heart of the Valley.

I understand that I have a responsibility to protect my own log-in and password information, and that Heart of the Valley will not be held liable for breaches of confidentiality arising from unauthorized use of such information.

____
Signature of Patient/ Legal Guardian/ Durable Power of Attorney for Health Care

____
Print Patient's name

____
E-mail address (please print legibly)