Heart of the Valley Pediatric Cardiology

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: _____

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Please follow us! @hotpvc @heartofthevalleypc Heart of the Valley Pediatric Cardiology

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 #: _____

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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 Aero chamber 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: _____

Any other important health information you would like the doctor to know?

_____

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

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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 (i.e. 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

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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 fifteen dollar ($15.00) 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 two-hundred $200.00 fee will be charged for missed appointments not cancelled within (48) forty-eight business hours prior to the scheduled appointment.

Heart of the Valley Pediatric Cardiology (HOTV) requires a credit card on file to be charged for any outstanding balances over thirty (30) days.
Heart of the Valley Pediatric Cardiology (HOTV) requires collection of payment for patients with high deductibles. 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. _____ **Initials**
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 (Medi-Cal, etc.) or private insurance. _____ **Initials**
3. Telemedicine: Email or phone communication is set up for simple clarifications from recent visits and/or management of side effects of recently prescribed therapy. Detailed responses or questions are billed to patient as self- pay/private- pay directly to patient at $125.00 dollars per encounter/topics. _____**Initials**
4. Authorizations for medications and procedures are billed to the patient as a method of self- pay/private- pay at $35.00 dollars per medicine or visit. If an appeal is required, additional fees will apply _____**Initials**
5. There is a $45 charge for all returned checks._____ **Initials**
6. A $15.00 administrative fee will be added to all copayments not paid on the day of service. _____ **Initials**
7. A late fee of twenty-five dollars ($25.00) per month will be assessed on any outstanding balances exceeding 30 days**.**_____ **Initials**
8. A $200.00 fee for ALL patients will be charged for missed appointments not cancelled within (48) forty-eight business 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. _____ **Initials**
9. If your appointment is scheduled for a Monday or a Tuesday, cancellations must made by Thursday by noon. If cancellations are not made by Thursday at noon, the cancellation fee of $200 will be charged. **Cancellations/Rescheduling will not be accepted over the weekend**._____ **Initials**
10. 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**

Signature _____ Relationship _____ Date_____

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UNDERSTANDING, ASSIGNMENT AND RELEASE:

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.

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**.** _____ **Initials**

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.

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 _____ Relationship _____ Date_____

Please Print Name of Parent/Guardian:_____

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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? _____
  _____

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Rectangle®

Heart of the Valley Pediatric Cardiology realizes that the trend in medical insurance is to shift more of the cost of care onto the patient. This means that our patients are incurring larger bills for their medical treatment and many are unable to plan easily for a large and unexpected bill. We chose Rectangle® because it gives you the convenience of spreading your payments over time to ease the crunch of your medical costs.

About Rectangle®

Rectangle® is an electronic funds transfer (EFT) service that administers monthly bank and credit card drafts for businesses all over America.

Rectangle® is a system that allows us to schedule payments to credit or debit cards at times that are convenient for you, our patient, or for future dates when we are able to determine the exact amount you will owe. We take the "electronic imprint" of your card at the time of your visit and process the payment after we receive the correct balance from the insurance settlement. We can also set up a convenient schedule to pay your bill over an extended period or to pay any existing past due balance.

Rectangle® is an authorized merchant processor for Visa/MasterCard/Discovery transactions and is affiliated with HSBC Bank USA, Concord EFS National Bank, and JP Morgan Chase NA. As an authorized merchant processor, Rectangle® must and does meet all PCI Security Council (the organization that regulates credit card transaction security) requirements.

Rectangle® does not add a finance charge to the patient.

Heart of the Valley Pediatric Cardiology believes that our patients will greatly benefit from the use of the Rectangle® System. We offer our patients the best care available and look forward to offering the most up-to-date payment method available today.

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

__ Payment by cash
__ Payment by check
__ Payment by credit card
__ Automatic monthly billing to your Visa or MasterCard
__ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to the office before treatment.

Our office is a fully approved and accredited user of the Visa a11d MasterCard Health Care Program which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

Name of Patient: _____

Date: _____

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AUTHORIZATION:

Single Payment per Visit

☐ I authorize Heart of the Valley Pediatric Cardiology to keep the electronic imprint of my card and my signature-on-file beginning on this date and ending one year later and to charge my credit/debit card for the balance of charges related to all transactions during that time after receiving my explanation of benefits after 15 days from billing date.

Cardholder: _____ Acct Number ending in: _____ Bank_____
MC/VISA/DISC

Signature: _____ Date: _____

OR

Monthly Recurring Payment Plan

☐ I authorize Heart of the Valley Pediatric Cardiology to keep the electronic imprint of my card and my signature-on-file and credit/debit for 4 equal recurring payments and a final payment that is less than the recurring amount beginning at the billing date and continuing MONTHLY until a total of my balance due has been paid.

Cardholder: _____ Acct Number ending in: _____ Bank_____
MC/VISA/DISC

Signature: _____ Date: _____

I authorize HOTV to email my authorization receipt to Email: _____

Heart of the Valley
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Heart of the Valley
Pediatric Cardiology