HEART, ARTERY, & VEIN CENTER

Heart Artery and Vein Center
Patient Registration Form

PATIENT INFORMATION (Please print Last , First, & Middle)			
Patient Name:			Home Phone: ( )
			Work Phone: ( )
Spouse Name:			Email Address:
Address:		City:	State and Zip Code:
Birth Date: / /	____ Male ____ Female	Social Security Number:	Family Physician:
Employer Name:			Occupation:
Employer Address, City & State:			

Insurance Company	Subscriber's name	Subscriber's Address	Subscriber's Birth Date
1.			/ /
2.			/ /

RESPONSIBLE PARTY (PARENT OR GUARDIAN)			
Name (Last, First, Initial):			Home Phone: ( )
			Work Phone: ( )
			E-mail Address:
Mailing Address:		City:	State and Zip:
Birth Date: / /	____ Male ____ Female	Social Security Number:	Marital Status (please circle one): Married Single Other
Employer Name:		Employer Address, City & State:	

I GIVE PERMISSION FOR HAV TO DISCUSS MY PERSONAL HEALTH INFORMATION WITH THE FOLLOWING INDIVIDUAL:

NAME	RELATIONSHIP TO PATIENT	COMMENTS

OTHER INFORMATION

Is This Your First Visit To HAV? Yes No

New Patients - How Did you Hear About Us? ☐ Family/Friend ☐ Physician Referral ☐ Provider Directory ☐ Advertisement (what source?_____) ☐ Other _____

We appreciate your feedback. Comments?

_____

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Home Phone:
		Work Phone:
Address, City & State:		Cell Phone:
_____		_____

FINANCIAL AGREEMENT

I, the undersigned, authorize direct payment to Heart Artery and Vein Center. I acknowledge that I will be financially responsible for all charges not paid by my insurance. If it becomes necessary for third party collection, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees. There will be a $12.00 service charge on all returned checks. In addition, I authorize Heart Artery and Vein Center to release information, as necessary, in order to facilitate treatment, payment or other healthcare operations.

SIGNATURE:_____ DATE _____

HEART, ARTERY, & VEIN CENTER

Health History Intake Form

Patient Name:_____

Date of Birth:_____**Age:**_____

Previous Primary Care Physician (if any):_____

Pharmacy:_____City & Zip Code:_____

Other Physicians involved in your care:_____

_____

Allergies (Medication/Food, indicate reaction): ☐ None ☐ Latex ☐ Adhesive Tape

_____

_____

_____

Medication List: (Please list name/dose/frequency, provide list, or present medications to MA)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Habits:

Alcohol: ☐ None ☐Yes: How many drinks/day_____frequency/week_____

Tobacco: ☐ None ☐Yes: Chew or smoke?_____How many/day_____since_____

Other Recreational Drugs: ☐ None ☐Yes: What kind_____How many/day _____

Social History:

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled Current

Occupation_____Former Occupation _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner

Children (age):_____

Past Surgical History (indicate date if known)

☐ None	_____	☐ Adenoidectomy	_____
☐ Cataracts	_____	☐ Coronary Bypass	_____
☐ LASIK	_____	☐ Cardiac Stents	_____
☐ Tonsillectomy	_____	☐ Pacemaker	_____
☐ Thyroidectomy	_____	☐ Heart Valve	_____

- ☐ Gall Bladder _____
- ☐ Appendectomy _____
- ☐ Bowel/Stomach Resection _____
- ☐ Hemorrhoidectomy _____
- ☐ Bariatric Surgery _____
- ☐ Hysterectomy _____
- ☐ Endoscopy _____
- ☐ Colonoscopy _____
- ☐ Hernia _____
- ☐ Spinal Surgery _____
- ☐ Tubal Ligation _____
- ☐ Bladder Surgery _____
- ☐ Prostate Surgery/Resection_____
- ☐ C-Section _____
- ☐ Orthopedic/Joints _____
- ☐ Erectile Dysfunction _____
- ☐ Other _____

Past Medical History (indicate date if known)

- ☐ Stroke _____
- ☐ Seizures _____
- ☐ Diabetes (Type I or Type 2) _____
- ☐ Thyroid Disease _____
- ☐ High Blood Pressure _____
- ☐ Blood Clots (Pulmonary Emboli or DVT) __
- ☐ Heart Burn, Reflux _____
- ☐ Stomach Ulcers _____
- ☐ Heart Disease _____
  - ☐ Coronary Disease _____
  - ☐ MI/Heart Attacks _____
  - ☐ Congestive Heart Failure _____
  - ☐ Atrial Fibrillation _____
  - ☐ Angina _____
  - ☐ Valve Disorder _____
- ☐ High Cholesterol _____
- ☐ Gastrointestinal Bleeding _____
- ☐ Hepatitis (A, B, C) _____
- ☐ HIV/AIDS _____
- ☐ Chronic Wounds (Ulcers) _____
- ☐ Cancer (Type) _____
- ☐ COPD (Emphysema, Bronchitis) _____
- ☐ Asthma _____
- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Gout _____
- ☐ Osteoporosis _____
- ☐ Erectile Dysfunction _____
- ☐ Other _____

Family History (indicate date if known)

- ☐ Stroke _____
- ☐ Seizures _____
- ☐ Diabetes (Type I or Type 2) _____
- ☐ Thyroid Disease _____
- ☐ High Blood Pressure _____
- ☐ Blood Clots (Pulmonary Emboli or DVT) __
- ☐ Heart Burn, Reflux _____
- ☐ Stomach Ulcers _____
- ☐ Heart Disease _____
  - ☐ Coronary Disease _____
  - ☐ MI/Heart Attacks _____
  - ☐ Congestive Heart Failure _____
  - ☐ Atrial Fibrillation _____
  - ☐ Angina _____
  - ☐ Valve Disorder _____
- ☐ High Cholesterol _____
- ☐ Gastrointestinal Bleeding _____
- ☐ Hepatitis (A, B, C) _____
- ☐ HIV/AIDS _____
- ☐ Chronic Wounds (Ulcers) _____
- ☐ Cancer (Type) _____
- ☐ COPD (Emphysema, Bronchitis) _____
- ☐ Asthma _____
- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Gout _____
- ☐ Osteoporosis _____
- ☐ Erectile Dysfunction _____
- ☐ Other _____

HEART, ARTERY, & VEIN
CENTER

7206 N Milburn Ave Ste 105 Fresno CA 93722
Tel: (559) 224-5003
Fax: (559) 271-8040
havfresno.com

RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____ DOB: _____

I, _____ (patient), authorize the release of my personal medical and/or billing information to the following facilities and/or persons:

Facility/Person: Heart, Artery, and Vein Center of Fresno

Address: 7206 N Milburn Ave Ste 105, Fresno, CA 93722

Telephone: (559) 224-5003

Check all that apply:

___ Medical Records

___ Billing Records

___ Tests/Scans/X-Rays

I understand that by signing this release, Heart, Artery, and Vein Center of Fresno and its affiliated doctors have my approval to release my personal medical records as noted above. I understand that this medical release will remain in effect unless revoked by me in writing.

Signature: _____

Date: _____

HEART, ARTERY, & VEIN
CENTER

Office Policies

Our goal is to provide quality individualized medical care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment
In order to be respectful of the medical needs of other patients, please be courteous and call Dr. Srivatsa's office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 72 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

How to Cancel Your Appointment
To cancel your appointment, please call 559-224-5003. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 72 hour advance notice.

No Show Policy: A "no-show", is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". This includes arriving 15 minutes after your scheduled appointment.

The first time there is a "no-show", late cancellation, or cancellation without a reasonable excuse there will be a fee of $25.00 for an office visit, $150.00 for an ultrasound study, and $250.00 for a surgical procedure or nuclear study. Two cancellations or "no-shows" for a surgical procedure or nuclear study will result in dismissal from our practice.

Patient Name: _____

Patient Signature: _____ Date: _____

HEART, ARTERY, & VEIN
CENTER

Narcotic Prescription Policy

Due to the alarming rate of narcotic pain medication abuse/dependence, it has become necessary for physician practices to closely manage patient use of prescription narcotic pain relievers, such as Vicodin, Vicoprofen, Hydrocodone, Tylenol #3 w/codeine, Percocet, Percodan, Lorcet, Lortab and Morphine products.

The Narcotic Prescription Policy of Heart, Artery, and Vein Center is as follows:

No narcotic pain relievers will be prescribed at the time of initial consultation. The referring physician should manage all pain medication until the time that a final treatment plan has been recommended by this office. It is unlikely that a final treatment plan can be recommended at the initial visit since most patients will not have had all of the necessary diagnostic test required to form an accurate diagnosis (i.e., MRI, X-rays, EMG, CT scan, etc.).

Once the final diagnosis has been made, this office will recommend a treatment plan that may or may not include the short-term use of narcotic pain medication.

In the event surgery has been recommended, this office will render the post-operative pain management. Narcotic pain management in the post-operative period may not exceed one month.

In the event a non-operative treatment plan has been recommended, pain management can be rendered by either the primary care physician (PCP).

Regional pharmacies monitor patient use of narcotic pain medications and contact the prescribing physician(s) if a patient is receiving narcotic pain medication from more than one physician. If this office receives notification, from any source, that a patient is receiving narcotic pain medication from more than one physician, prescribing of such medication by this office will be immediately suspended.

Under no circumstances will narcotic pain medication be prescribed beyond a 30-day period. If narcotic pain management is required beyond 30 days, then a referral to a Chronic Pain Specialist will be made.

In the event of suspected narcotic abuse, further prescriptions of narcotic pain medications will not be made.

In the event of documented narcotic abuse, further prescriptions will not be made and the patient may be discharged from care.

In the event of suspected narcotic dependence, a referral to a Dependency Treatment Specialist can be made, at the patient's request.

If a patient has not been seen in this office during the preceding 3 months, no prescriptions will be "called-in" to the pharmacy without re-assessment of the patient.

If a request for a prescription refill has been made by telephone, the physician must review your chart prior to contacting the pharmacist. Therefore, your request may not be processed immediately. It is the policy of this office to complete all legitimate requests within 48 business hours. Therefore, requests made on Friday may not be completed until the following week.

Patient Name: _____

Patient Signature: _____ Date: _____

Heart Artery and Vein Center

NOTICE OF PRIVACY PRACTICES

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

This notice describes the information privacy practices followed by our employees, staff, and other office personnel. The practices described in this notice will also be followed by physicians/providers with whom we have arranged to provide "call coverage" for our practice.

This notice applies to the information and records we have about your health, health status and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose your health information and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

We may use and disclose health information for the following reasons:

For Treatment: We may use your health information to provide you with medical treatment and coordination of care within or outside of our practice. We may need to disclose your health information to other providers, nurses, technicians, office staff, laboratories, imaging facilities, hospital facilities or other personnel who are involved in your health care.

For Payment: We may disclose your health information to submit billing to your health plan or a designated third party for payment of services you receive at this office. We may also be required to disclose your health information in order to obtain prior authorizations when required, or to determine whether your plan will cover the needed treatment.

For Health Care Operations: We may use and disclose your health information to run the practice and to ensure that all of our patients receive quality care. This may include our practice's inclusion in quality care initiative programs.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care. We may leave a generic (non-specific as to medical information) appointment reminder messages on your voice-mail or with a person answering your phone.

SPECIAL SITUATIONS:

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for health research projects.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Worker's Compensation: We may release health information about you for workers' compensation claims.

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Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for state and federal agencies to monitor the health care systems, government programs, and compliance with civil rights laws.

Legal Requests: We may disclose health information about you in response to a court or administrative order, search warrant or

subpoena.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

National Security: We may release health information for special government functions such as military, national security and presidential protective services.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your written agreement to do so. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object and/or in the event you are not capable of giving consent due to your incapacity in a medical emergency.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We can use and share health information about you through electronic health information exchanges so that information is readily available to participating healthcare providers, regardless of where they are treating you. Health information exchanges are also used to improve treatment, billing and operations. You may choose to opt-out of healthcare providers accessing of your health information through the exchange. If you choose to do so, you must submit this in writing.

AUTHORIZATION:

When you give us required Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made. If we have HIV, substance abuse information or genetic information about you, we cannot release that information without your specific written authorization.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:
You have the following rights regarding health information we maintain about you:
Right to Inspect and Copy: You have the right to inspect and/or obtain a copy your health information. You must submit a written request to our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain circumstances.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must complete and submit this in writing. We may deny your request if you ask us to amend information that: a.) We did not create, b.) Is not part of the health information that we keep, c.) in our professional opinion is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures", if the disclosures are for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our office. It must state a time period.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may do so in writing.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you may complete this in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may request a copy of this notice at any time.

CHANGES TO THE TERMS OF THIS NOTICE:

We reserve the right to change this notice, and the changes will apply to all medical information we have about you as well as any information we receive in the future. A copy of the current notice will be available in our office.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office:

Heart Artery and Vein Center / Attention: Practice Manager 7206 N Milburn Ave Ste 105 Fresno CA 93722
Or
US Department of Health and Human Services, Office for Civil Rights 200 Independence Ave. SW Washington, DC 20201

There will be no penalty or retaliation for filing a complaint. Updated 05/09/2019

ACKNOWLEDGMENT AND CONSENT

I understand that **Heart Artery and Vein Center** (referred to below as "This Practice") will use and disclose **health information** about _____
(Name of patient)

I understand that his/her **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about his/her health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** his/her health information in order to:

- make decisions about and plan for his/her care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for his/her care and treatment;
- determine his/her eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of his/her health care; and
- perform various office, administrative and business functions that support his/her physician's efforts to provide him/her with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about him/her. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and his/her rights regarding his/her health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be available upon request.

I understand that I have the right to ask that some or all of his/her health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient or Guardian)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority: _____