CURE CARDIOVASCULAR CONSULTANTS

NEW PATIENT PACKET

There are six pages in this packet that will help us get a clearer picture of your medical history and physical health. Please note: SIGNATURES are required on pages 2, 4, and 6. Please bring this packet, along with the following checklist, to your first visit.

- Current Medication List
- Current Insurance Card
- Picture ID/Driver's License
- Recent Lab Work/Diagnostic Procedures
- Recent Hospitalization Records

If you have any questions, please call (760) 323-2174. We look forward to meeting you at your first visit!

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PATIENT INFORMATION

Date: _____ **Referring Physician:** _____

Patient Name: _____ **Date of Birth:** _____

Sex (Please circle): Male Female **Marital Status (Please circle):** Married Single Divorced

Address: _____ **City/State:** _____ **Zip:** _____

Mailing Address (if different from above): _____

Home/Cell Number: _____ **SSN:** _____ **Driver's License:** _____

Employer's Name and Address: _____

RESPONSIBLE PARTY (If different from patient)

Responsible Party: _____**Relationship to Patient:** _____**DOB:** _____

Home/Cell Number: _____ **SSN:** _____ **Driver's License:** _____

Address (if different):

_____

Employer's Name and Address:

_____

Nearest Relative/Emergency Contact: _____

Emergency Contact Home/Cell Number: _____**Relationship:** _____

INSURANCE COVERAGE (including Workman's Comp if applicable)

Primary: _____ **Secondary:** _____

Subscriber: _____ **Subscriber:** _____

DOB: _____ **DOB:** _____

Workman's Comp #: _____ **Date of injury:** _____

PLEASE READ AND SIGN

I request that payment of authorized health plan benefits be made on my behalf to Cure Cardiovascular Consultants for any services furnished by that physician/facility/supplier. I also authorize the release of any medical information necessary to process my claim. I realize that any insurance payments that may be received on my account may not represent full payment for services, and that I am responsible for the balance due on my account. Additionally, if I fail to show up for an appointment (without 24-hour notice), I will be charged the applicable co-pay.

Print Name: _____ **Signature:** _____ **Date:** _____

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Patient Name: _____ **Date:** _____

Past Medical History (circle all that apply)

Heart Attack	Heart Surgery
Tachycardia	Valve Replacement
Atrial Fibrillation	Angiogram
Cong Heart Failure	Angioplasty
High Blood Pressure	Stent Placement
High Cholesterol	Echo
Periph Vasc Disease	Stress Test
Abd Aortic Aneurysm	Nuclear Study
Kidney Failure	Ablation
Fainting/Dizziness	Pacemaker
Asthma	Defibrillator
Diabetes	CVA/TIA/Stroke

Other: _____

Social History

Smoker? Y/N
If yes, how many per day? _____
Quit? Y/N When? _____
Alcohol Use? Y/N
Street Drug Use? Y/N
Exercise? Y/N
If yes, how often? _____
Working? Y/N
Race: _____ Decline to answer
Preferred Language: _____

Any Allergies to Medication? Y/N
If yes, please specify: _____

Family History:

Y/N?	Heart Attack	Heart Surgery	Stroke	High Cholesterol	High Blood Pressure	Diabetes	Death (Age)
Father							
Mother							
Siblings							

Chief Complaints (circle all that apply):

General:
Weight Change
Fatigue
Snoring
Allergies

Musculoskeletal:
Joint Pain
Back Pain

Cardiac:
Chest Pain
Heart Pounding
Shortness of Breath
Leg Swelling

Venous:
Varicose Veins
Ulcerations
DVT/Clots

Neurological:
Weakness
Imbalance
Double Vision
Numbness/Tingling

Psychological:
Depression
Anxiety

Gastrointestinal:
Nausea
Stomach Pain
Bloating

Respiratory:
COPD
Wheezing
Sleep Apnea
Oxygen use @ home

List All Medications with Dose and Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

If needed, continue list on the reverse of this page

Primary Care Physician: _____

Preferred Pharmacy (Address & Phone number): _____

_____

CURE CARDIOVASCULAR CONSULTANTS

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize _____ (Name of practice or provider) to obtain any and all medical records concerning my care from any physician, hospital, or other healthcare professional that has provided medical care to me in the past. I also authorize the practice to release any and all medical records concerning my care to any physician, hospital, or other healthcare professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third-party administrator, or managed care company.

_____ _____

Patient Signature **Date Signed**

_____ _____

Printed Name **Date of Birth**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with the federal government's privacy rule implementation fo the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of Cure Cardiovascular Consultants (CCC) to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **DO NOT** authorize CCC to release any and all information concerning my medical care to any individual except as set forth below.

_____ I authorize CCC to verbally release any or all information concerning my medical care to the following individual (s):

_____ _____

Name(s) **Relationship to Patient**

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**

CURE CARDIOVASCULAR CONSULTANTS

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 of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you, and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay any healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. Your protected health information may be provided to a physician to whom you've been referred to, to ensure that the physician has the necessary information to diagnose or treat you in regards to the continuity of your care.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for the hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign your name and indicate the physician you are to be seeing. We may also call you by name in the waiting room when you are ready to be seen by the physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, Workers' Compensation, and inmates. Required uses and disclosures: under the law, we must make disclosures to you and when requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

CURE CARDIOVASCULAR CONSULTANTS

Patient Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in, for notification purposes, as described in this notice of privacy practices. You must state the specific restriction requested and to whom you want the restrictions to apply towards.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from CCC by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures CCC have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to CCC or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before August 1, 2017.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to your protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this notice of our privacy practices:

Print Name: _____ Signature: _____ Date: _____