Palo Alto Medical Foundation
A Sutter Health Affiliate

Welcome to Cardiology at Palo Alto Medical Foundation!

Following the instructions below will simplify your first visit to our office.

Enclosed you will find:

- **Our registration form,**
- **A short medical history form, and**
- **An appointment card with your upcoming appointment date and time.**
- **If your appointment is for a test, you may find instructions for that**
- **as well.**

Bring with you to the appointment:

- **The completed registration and medical history forms.**
- **Your current medical insurance card(s) so we can make copies of your cards for billing purposes.**
- **Also, *bring a photo ID* with you.**

Please arrive 30 minutes in advance for your appointment.

Since initial appointments require additional time, if you arrive <u>after</u> your scheduled appointment time, your appointment may have to be rescheduled for another day. If you have not filled out the forms in advance, please arrive 20-30 minutes early to give you time to complete the forms.

If you have any questions or concerns, please do not hesitate to call us. We will be happy to answer any questions you may have regarding your upcoming visit. Our number is (650) 652-8600.

Please be sure to have any pertinent medical records from your Primary Care Physician (PCP) faxed to our office in advance. Our fax number is (650) 652-8601. These records are most important to your care. Contact your PCP directly for the records prior to coming for your visit.

Thank you in advance for your cooperation. We look forward to serving your medical needs.

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Financial Policy

We are committed to providing you with the best possible medical care and are pleased to discuss our professional fees with you at any time. Our billing department can be reached directly by calling (650) 259-5350. Your clear understanding of our financial policy is important to our relationship.

All patients must complete our patient information sheet and supply us with a copy of their insurance card(s) on a yearly basis. If any information has changed during the year, we will ask that you fill out new forms and allow us to take copies of your new insurance card(s).

Payment at the time of service is required as follows:

HMO Patients:	Co-Payment, if applicable, provided you are eligible and you or your PCP/Medical Group has furnished us with proper pre-authorization for treatment.
PPO Patients:	Co-Payment, if applicable, and/or annual deductible amount.
POS Patients:	Co-Payment, if applicable. Please note, if we are not contracted with your 1st tier medical group, e.g., Brown & Toland or Hill Physicians Medical Group, the claim will be submitted using your 2nd tier "PPO" level of benefits or your 3rd tier "out-of-network" benefits. A co-insurance or deductible may apply.
Cash Patients:	Payment in full is due at the time of visit unless a prearranged financial agreement has been arranged.

We accept VISA and MasterCard.

Billing Your Insurance:
As a courtesy to you, we will bill your insurance for your services. However, to do so, we must have the most up to date insurance information provided to us prior to services being rendered. Otherwise, payment in full will be required.

We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, co-payments, covered charges, etc. other than to supply pertinent medical information as required.

You are responsible for timely payment of your account.

Thank you for reviewing our policy. Please bring any questions or concerns to the attention of our billing office.

Please sign below as an indication that you have read and agree to the above Financial Policy.

_____ _____

Patient/Responsible Party Date

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Patient Registration

☐ **New Patient** ☐ **Estab. Patient**

Name : _____, _____ _____
Last First MI

Date of Birth: ____/____/____ **Age**: _____ **Marital Status**: _____

SS#_____-_____-_____ **Referring MD**:_____

Home Address: _____, _____, _____
Street City State Zip

Phone Numbers:
Home: _____ **Work**: _____

Email: _____

Emergency Contact Name: _____
Phone: _____ **Relationship**: _____

Employer: _____
Address: _____, _____, _____
Street State Zip

Primary Insurance: _____
Insured's Name:_____ Relationship to patient: _____
ID# _____ Group# _____

Secondary Insurance:_____
Insured's Name:_____ Relationship to patient: _____
ID# _____ Group# _____

Authorization for Payment of Benefits to Physician

I hereby authorize payment of medical and/or surgical benefits directly to Cardiovascular Associates of the Peninsula, Inc. for services rendered to me. I understand that I am financially responsible for charges not covered or denied by my insurance for whatever reason.

_____ _____
Signature Date

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Ethnicity, Race, Language Questionnaire

We are asking for your ethnicity and race because some people have higher risks of developing certain disease, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly.

We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care.

Please fill in the information below. We appreciate your participation. Thank you.

1. Ethnicity - Please check the box that best describes you.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

2. Race - Please check the box that best describes you. (up to 2 boxes)

☐ Asian
☐ Black/African American
☐ Hispanic or Latino
☐ Multiracial
☐ Native American
☐ Native Hawaiian or Other Pacific Islander
☐ Other
☐ Unknown/Not Reported
☐ White/Caucasian
☐ I prefer not to answer

3. Please indicate your preferred spoken language. (We are required by law to request this information.)

☐ I prefer not to answer

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NAME: _____ **DATE OF BIRTH:** _____

TODAY'S DATE: _____

Marital Status	**Children**	**Family History**
O Single O Married O Divorced O Previously Widowed O Separated O Widowed O Domestic Partner	O Yes Son(s) _____ O No Daughter(s) _____ Your Occupation _____ O Disabled O Retired	Coronary Artery Disease O Yes O No O Unknown

Tobacco	**Alcohol**	**Exercise**	**Advance Directives**
O Yes O Former O No Type _____ Year Quit _____ Packs/Day _____ Years Smoked_____	O Yes O Former O No Year Quit _____ O Rarely O Social #_____ per_____	O Physically unable O Active O Inactive Type of Exercise _____ minutes _____ per _____	O None O Do Not Resuscitate O Health Center Proxy O Living Will O I want to speak with the doctor

Diabetes	**Hypertension**
O Yes O No Year Diagnosed _____	O Yes Year Diagnosed _____ O No

MEDICAL SYMPTOMS – Check any you are currently experiencing (new patient), OR since your last visit:

Constitutional	**Yes**	**No**
Fatigue	O	O
Fever	O	O
Night Sweats	O	O
Weight Gain	O	O
Weight Loss	O	O

Cardiac	**Yes**	**No**
Chest Discomfort	O	O
Palpitations	O	O
Fainting	O	O
Dizziness	O	O

Neurological	**Yes**	**No**
Headache	O	O
Memory Loss	O	O
Seizures	O	O

Eyes	**Yes**	**No**
Vision Change	O	O

Vascular	**Yes**	**No**
Pain in legs when walking	O	O
Swollen Ankles	O	O

Psychiatric	**Yes**	**No**
Anxiety	O	O
Depression	O	O
Sleep Disturbance	O	O

ENT	**Yes**	**No**
Hearing Loss	O	O
Sore Throat	O	O

Gastrointestinal	**Yes**	**No**
Abdominal Pain	O	O
Bleeding	O	O
Nausea	O	O
Reflux	O	O

Musculoskeletal	**Yes**	**No**
Joint Pain	O	O
Muscle Pain	O	O

Pulmonary	**Yes**	**No**
Cough	O	O
Short of Breath	O	O
Snoring	O	O

Dermatological	**Yes**	**No**
Rash	O	O

Hematological	**Yes**	**No**
Easy Bleeding	O	O
Bruising	O	O

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CHEST PAIN EVALUATION FORM

Name: _____ **Date:**_____
DOB: _____

1. How long have you had chest discomfort?
   - ☐ Less than one week
   - ☐ One to two weeks
   - ☐ Two to four weeks
   - ☐ One to two months
   - ☐ More than six months
2. How long does your chest discomfort last?
   - ☐ Seconds
   - ☐ Minutes
   - ☐ Hours
   - ☐ Continuous
3. Does it occur with exercise? **Yes / No**
4. Does it go away when you stop exercising? **Yes / No**
5. What makes it better? _____
6. Where is your chest pain? _____
7. Does it go up your neck? **Yes / No** Or down your arm? **Yes / No**
8. Does it hurt more when you take a deep breath or cough? **Yes / No**
9. Describe your chest pain:
   - ☐ Stabbing
   - ☐ Burning
   - ☐ Tightness
   - ☐ Heaviness

CARDIAC RISK FACTORS

1. Have you ever smoked? **Yes / No** If so, how many years? ___When did you quit? ___
2. Does anybody in your family have heart problems? At what age? _____
   _____
3. Do you have high blood pressure? **Yes / No**
4. Do you have high cholesterol? **Yes / No**
5. Do you have diabetes? **Yes / No**
6. Have you ever had radiation therapy to your chest before? **Yes / No**
7. What medicines are you taking now? _____
   _____
8. Do you have acid indigestion or heartburn? **Yes / No**
9. How much do you weigh? _____

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First Name _____ **Last Name**_____ **Date:** _____

DOB: _____ **Age** _____ **Sex** _____ **Primary Care Physician:** _____

Marital Status_____**No. of Children** _____ **No. of Grandchildren** _____

Current Medications:
(Please use back of form if more room needed)

Name: _____ Dose: _____

Over the counter medications: _____ _____ _____

Medication Allergies/Intolerances:

Name: _____ Reactions: _____

Have you ever had a dye reaction (x-ray/ contrast dye/iodine allergy)? _____

Major Surgeries/Procedures:
Type & Date: _____

Medical History (Past or Present)

☐ Heart	☐ Brain/Nervous System	☐ Weight Fluctuations
☐ Blood Pressure	☐ Lungs	☐ Bleeding Problems
☐ Diabetes	☐ Intestinal	☐ Mobility Difficulties/Falls
☐ Cholesterol	☐ Kidney/Urinary Tract	☐ Memory Problem
☐ Stroke	☐ Arthritis	☐ Emotional/"Nerves"
☐ Blocked Arteries/Aneurysms	☐ Hormonal RX	☐ Vision/Hearing
☐ Headaches/Migraine	☐ Cancer	☐ Sexual Difficulty

Heart Tests (place and date):

Cholesterol/Blood Tests
Treadmill
Echo
Rhythm Monitors
Angiogram
Previous Cardiologist(s)

Family History

	Relatives		Relatives
Angina		Diabetes	
Heart Attack		Heart Disease	
Bypass Surgery		High Blood Pressure	
Balloon Angioplasty		Stroke	
Bleeding Disorder		Sudden Cardiac Death	
Cancer		Other	

Habits

☐ Alcohol: Type _____ ☐ Smoke: Packs Daily _____
Amount _____ No. of Years_____ Date Quit _____
☐ Coffee: Cups Daily _____ Other Caffeine _____
☐ Exercise: _____min. _____ x/week. Type: _____
☐ Recreational Drugs: Type _____ Amount _____

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For Clinic Use Only	
MRN	
Scan Doc Type	
Receipt Date	
Patient's DOB	

Request to Restrict the Use and Disclosure of Health Information

(Please type or print legibly in blue or black ink)

You have the right to request that PAMF restrict how we use or disclose your health information, or the health information of a patient for whom you are the parent or legal guardian, for purposes of treatment, payment, or healthcare operations. We may agree to your restriction if we can reasonably do so and if, in our best judgment, the requested restriction will not interfere with your treatment, our ability to bill and collect payment for our services or to perform necessary healthcare operations. Please realize:

- Your restriction will apply to all health information. It cannot be limited to certain types of information or information from a particular department.
- All information collected while the restriction is in place will be restricted unless you cancel this agreement in writing.
- We will notify you within 10 working days whether or not we are able to grant your restriction.
- The restriction will not apply to information needed to provide you with emergency treatment.
- This restriction will not apply to information PAMF is legally responsible to report.
- Requests for restricted use and disclosure of health information cannot apply to past uses or disclosures. They can be applied forward in time from the date and time they are accepted.
- If you wish to avoid all communication with your insurance company, or with the guarantor of your bill, you must arrange for confidential billing in advance. Confidential billing cannot be applied to a service that has already been rendered. Confidential billing requires advance payment. Contact Patient Accounting - (650) 812-3838, in advance, to inquire about payment arrangements.
- You may terminate the restriction at any time by completing a *Request to Rescind Restriction for Use and Disclosure of Health Information.*
- We may cancel the restriction if we are no longer reasonably able to comply. We will notify you in writing, if we terminate your restriction.

❒ I request that PAMF not use or disclose my health information as follows:

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Your name, if not patient: _____ Relationship to Patient: _____

Signature: _____ Date: _____

For Official Use Only

❒ PAMF agrees to the restrictions you have requested above. Any exceptions are listed on the attached form.

❒ PAMF is unable to agree to the restrictions you have requested above.

❒ As of ____(date)_____ PAMF can no longer reasonably comply with this restriction. It has been terminated.

Signature: _____ Title: _____ Date: _____

Mail to: Privacy Officer, Palo Alto Medical Foundation, 795 El Camino Real, Palo Alto, CA 94301

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Acknowledgement of Receipt of Notice of Privacy Practices.

I acknowledge receipt of the *Notice of Privacy Practices* of Cardiovascular Associates of the Peninsula.

I understand that this is just an acknowledgement of receipt – it does not obligate me in any way.

Name of Patient: _____

Signature: _____ Date:_____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed by office staff if no signature is obtained. (Check one):

❒ No signature was obtained because this is an emergency treatment situation.

❒ Describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained: _____
_____
_____

Signature of provider representative: _____ Date:_____

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Effective Date: March 1, 2003

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Why am I receiving this Notice? We are required by law to maintain the privacy of your health information. We are required to inform you of our legal duties and privacy practices where your protected health information is concerned.

This notice contains a summary of our health information privacy practices and of your rights relating to your health information. In the absence of an express statement to the contrary, this notice is not intended to preclude or restrict uses or disclosures of health information that are otherwise permitted by law, or to give you rights that we are not required by law to give you.

We are required to follow the terms of this Notice of Privacy Practices. We also have the right to change the terms of this notice, and to make the new notice effective for all health information we maintain. We will provide an updated copy of this notice to you if we make any changes to it by emailing the revised notice to you if you have agreed to receive electronic notice, or by mailing it to you at your address in our records.

How do we use and disclose my health information? We maintain health-related records about you, including medical records and billing and payment information. We use this information and disclose it to others for the following purposes:

Treatment: We use your health information to provide health care to you and to coordinate your health care with other providers, and we disclose it to other health care providers to enable them to provide health care services to you. For example, if we refer you to a specialist physician we send all or a part of your health record to the specialist to assist him or her in evaluating and treating you.

Payment: We use and disclose your health information to obtain payment for health care services we provide to you, including determining your eligibility for benefits. For example, we may send a claim to your insurer that contains information about the services we provided to you, or we may send a bill to a family member who is responsible for paying for your care.

Health care operations: We uses and discloses your health information as necessary to enable us to operate our medical practice. For example, we use our patients' claims information for our internal financial accounting activities, and we review health records to ensure quality.

We also disclose health information to our contractors and agents who assist us in these functions, but we obtain a confidentiality agreement from them before we make such disclosures for payment or operational purposes. For example, companies that provide or maintain our computer systems may have access to computerized health information in the course of providing services to us.

Contacting you: We may contact you to provide appointment reminders or information about treatment options available to you. We may also contact you about other health-related services that may interest you.

Others involved in your care: Unless you object, we may disclose medical information to a friend or family member who is involved in your care, to the extent we judge necessary for their participation.

***Other Disclosures*:** We may disclose health information without your authorization to government agencies and private individuals and organizations in a variety of circumstances in which we are required or authorized by law to do so. Here are the general kinds of disclosures we may be required or allowed to make without your authorization:

- Disclosures that are required by state or federal law
- Disclosures to public health authorities or to other persons in connection with public health activities
- Disclosures to government agencies authorized to receive reports of abuse or neglect of children or dependent adults, or domestic violence
- Disclosures to agencies responsible for overseeing the health care system, for audits, inspections or investigations
- Disclosures for judicial and administrative proceedings, such as lawsuits
- Disclosures to law enforcement agencies
- Disclosures to coroners and medical examiners
- Disclosures to organ procurement agencies, if you are an organ donor or a possible donor
- Disclosures to researchers conducting research under the auspices of an Institutional Review Board or privacy board
- Disclosures to avert a serious threat to health or safety
- If you are a member of the armed forces or a veteran, we may release health information to your military command authority or to the veterans' administration to assist in determining your eligibility for veterans' benefit
- Disclosures to assist authorized federal officials in national security activities, or for the provision of protective services to officials
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the institution or official
- Disclosures to other agencies administering government health benefit programs, as authorized or required by law
- Disclosures to comply with workers' compensation laws.

Limitations: In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described above. For example, government health benefit programs may limit the disclosure of health information for purposes unrelated to the program. In addition, there are special restrictions on the disclosure of health information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

Authorization.: Except as described above, we will not permit other uses and disclosures of your health information without your written authorization, which you may revoke at any time in the manner described in our authorization form.

Your Rights

What rights do I have as a patient of the practice? As a patient of the practice you have the following rights:

- You have the right to ask us to restrict certain uses and disclosures of your health information. However, we are not required to agree to any restrictions requested by our patients.

- You have the right to receive confidential communications from us, for example by asking us to contact you at a particular telephone number, post office box or other address.

- You have the right to see and copy any certain records that we maintain. These include our medical records and billing records concerning you. Under certain circumstances, we may deny your request. If your request is denied, we will tell you the reason why in writing. You have the right to appeal the denial.

- If you feel the information in our records is wrong, you have the right to request us to amend the records. We may deny your request in certain circumstances. If your request is denied, you have the right to submit a statement for inclusion in the record.

- You have the right to receive a report of non-routine disclosures that we have made of your health information, up to six years prior from the date of your request (but not earlier than April 14, 2003). There are some exceptions: for example, we do not maintain records of disclosures made with your authorization; disclosures made for the purposes of treatment, obtaining payment for health services, or operating our medical practice; disclosures made to you; and certain other disclosures.

- If you received this notice electronically, you have the right to request a paper copy from us at any time.

The foregoing is a general statement of your rights. They are subject to all limitations permitted or required by law.

How do I exercise these rights? You can exercise any of your rights by sending a written request to our Privacy Official at the address below.

How do I file a complaint if my privacy rights are violated? You have the right to file a complaint with our Privacy Official if you believe your privacy rights have been violated. You must provide us with specific, written information to support your complaint. You may also file a complaint with the Secretary of Health and Human Services. We will not retaliate against you in any way for filing a complaint.

Contact us at:

Palo Alto Medical Foundation
1501 Trousdale Drive, 2nd Floor
Burlingame, CA 94010
(650) 652-8600

Contact the Secretary of Health and Human Services at:

Secretary of Health and Human Services
Office for Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201