WELCOME TO OUR PRACTICE

This information is provided to assist you in using our services effectively and efficiently.

REGISTRATION
Upon checking in our office staff will ask you to verify your address, telephone number, and insurance billing information. Please have a copy of your insurance card(s).

APPOINTMENTS
We see patients by appointment only. For appointment-related questions, you may contact us during normal business hours. We're open Monday through Friday from 8am-5pm. We are closed on federally-observed holidays. It's best to arrive at least 15 minutes prior to your appointment to allow for time to check in.

CANCELLATIONS AND NO SHOWS
Cancellations are accepted up to 24 hours prior. Providing less than 24 hours notice or not showing up to appointments will result in a fee of up to $150. Insurance does not cover this fee. Repeated failure to keep appointments may result in termination of the physician-patient relationship.

BILLING INFORMATION
Our billing office will process your claims to your insurance company(s). If you do not have insurance, we ask that you prepay for your initial visit and any diagnostic service and pay at the time of your visit for follow-up services. Our patient account representatives are available daily, except holidays, from 8am-4pm and Fridays from 8am-1pm to answer billing questions or to make payment arrangements. Please call (916) 878-5936 to answer any billing statement, insurance questions and payment arrangements.

After we bill your health insurance, you will be responsible for the remaining balance after your insurance (s) has paid their portion of the service. Please be sure that you understand the provisions of your insurance plan and what your responsibility is. Insurance coverage, provisions and restrictions are constantly changing. It is ultimately your responsibility to know what is included and excluded in your specific policy. We are not contracted providers for all insurance companies. You will receive a monthly statement stating your current balance. Please note that your payment is requested by the due date listed on the statement. Past due balances are written off to an outside collections agency.

FORMS COMPLETION
Medical necessity forms, clearance forms, disability forms, dental forms, or other procedure forms require your cardiologist to review your record and make a medical determination. Due to the liability, time and effort, our policy is to charge a fee for these forms that is not covered by insurance. The fee is $25 for the first page, then $5 for each additional page.

Please read, return and sign this form as an acknowledgement that you are aware of our office policies.

Patient Signature	Date
Printed Name (First & Last)	Patient Date of Birth

REGISTRATION FORM

(Please Print)

Today's Date ______________________ Primary Care Physician ______________________

PATIENT INFORMATION

Patient's Last Name ______________________ First ______________________ Middle __________

❑ Mr. ❑ Mrs ❑ Miss. ❑ Ms. Marital Status: ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Wid

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? ______________________

Former / Maiden Name ______________________ Sex ❑ F ❑ M Age________ Birth Date____/____/_____

Street Address ______________________ Primary Phone ______________________

P.O. Box__________________ City ______________________ State ____________ Zip Code__________

Occupation__________________ Employer______________________ Employer Phone No. ______________

Race: ❑ Caucasian/White ❑ African American ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese

❑ Other Pacific Islander ❑ Mexican ❑ Other Spanish ❑ Other______________________

Language: ❑ English ❑ Spanish ❑ Other______________________ Interpreter Needed: ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)______________________

Relationship to Patient ________________ Primary Phone ________________ Secondary Phone ____________

Alternate Contact Person ______________________

Relationship to Patient ________________ Primary Phone ________________ Secondary Phone ____________

Email Address:______________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Roseville Cardiology** or insurance company to release any information required to process my claim(s).

Patient/Guardian Signature ______________________ Date ______________

ROSEVILLE
Two Medical Plaza, Suite 175
Roseville, CA 95661
P: (916) 782-2146 F: (916) 782-4299

ROSEVILLE - Testing Department
Two Medical Plaza, Suite 150
Roseville, CA 95661
P: (916) 782-4180

LINCOLN
685 Twelve Bridges Road, Suite D
Lincoln, CA 95648
P: (916) 644-3148

AUBURN
11971 Heritage Oaks Place, Suite 7/8
Auburn, CA 95603
P: (530) 368-8001

POS Reorder # 1614576

Roseville Cardiology

PATIENT HISTORY

Patient Name ______________________ Family Doctor ______________________

MAJOR COMPLAINTS	DOCTORS SEEN IN LAST YEAR
1. ________	1. ________
2. ________	2. ________
3. ________	3. ________

Past History / Major Illnesses and Date (use reverse if needed):
1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Hospitalizations (include surgeries):
1. Where ____________ When ________ How Long ________
   Reason ______________________
2. Where ____________ When ________ How Long ________
   Reason ______________________
3. Where ____________ When ________ How Long ________
   Reason ______________________

Allergies:
1. ________ 2. ________ 3. ________

Medications (include all medication taken in the last month):
1. ________ 2. ________ 3. ________
4. ________ 5. ________ 6. ________
7. ________ 8. ________ 9. ________
10. ________ 11. ________ 12. ________

Date of Last EKG: ________ **Date of Last Chest X-Ray:** ________

FAMILY HISTORY	If Living		If Deceased	
	Age	**Health**	**Age**	**Cause**
Father ________				
Mother ________				
Brother or Sister				
1. ________				
2. ________				
3. ________				
4. ________				
Spouse ________				
Children				
1. ________				
2. ________				
3. ________				
4. ________				

Has any blood relative had?

Heart Trouble	❑ No	❑ Yes
High Blood Pressure	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes
Stroke	❑ No	❑ Yes
Cancer	❑ No	❑ Yes

NOTE: This is a confidential record of your health history and will be kept in this office. Information contained here will not be released, unless you authorize us to do so.

Social History:
Occupation ____________ Education ____________
Smoking: Yes_____ No_____ Packs per day ________ Years smoking ________
Alcohol: Type ____________ Amount ________ Frequency ________
Hobbies: ______________________
Diet: ❑ Regular ❑ Diabetic ❑ Lowfat ❑ Other
Exercise: ❑ Sedentary ❑ Walk Frequently 10 - 15 mins ❑ Very Active: Regular Workouts/Jogging/Biking

Roseville Cardiology

PATIENT HISTORY continued

Patient Name ______________________________

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINTS/BONE
- ☐ Pain, weakness
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles

SKIN CONTINUED
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

NEUROLOGICAL
- ☐ Seizures
- ☐ Weakness of arms or legs
- ☐ Trouble with balance
- ☐ Tremors
- ☐ Trouble talking
- ☐ Memory problems

MEN only
- ☐ Breast lump
- ☐ Erection difficulty
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other ______________________________

WOMEN only
- ☐ Abn Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other ______________________________

Roseville Cardiology

PATIENT PRIVACY FORM

Patient Name ____ Patient Date of Birth ______________________________

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice has been modified to be compliant with the September 2023 regulation changes. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety.
We are required to ask you to sign a one-time acknowledgement that you have received this summary. A copy of the full Notice is available upon your request.

Your rights as a patient
You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information
We are permitted to use your protected health information for treatment purposes to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as over hearing a conversation that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid, and considers them permissible.

For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes we require that they sign a contract in which they agree to protect the confidentiality of the information.

Disclosure of Protected Health Information Requiring Your Authorization
For disclosures that are not related to treatment, payment or operations we will obtain your specific written consent, except as described below.

Communications to You of Confidential Information by Alternative Means
If you make a written request, we will communicate confidential information to you by reasonable alternative means or to an alternative address.

Restrictions to Use and Disclosure
You may request restrictions to the 'use of' or 'disclosure of' your protected health information, and we will comply with your request unless a county, state, or federal order supersedes. In that event, only the minimal amount of information will be shared.

Access to Protected Health Information
You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which under specific circumstances, will be reviewed by a third party not involved in the denial.

Amendments to Medical Records
You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have the right to dispute such denials and have your objections noted in your medical record.

Accounting of Disclosures of Protected Health Information
You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment or operations, and disclosures that were made as a result of your written authorization.

Other Uses of Your Health Information
Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

How to Lodge a Complaint Related to Perceived Violations of Your Privacy Rights.
You may register a complaint about any of our privacy practices with our Privacy Officer without fear of retaliation, coercion or intimidation.

Telephone Consumer Protection Act (TCPA):
I agree that the facility, Roseville Cardiology or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

Notice to Patients:
Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email licensecheck@mbc.ca.gov, or call (800)633-2322.

Open Payments Database (Sunshine Act):
The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY OF NOTICE OF PRIVACY PRACTICE

I acknowledge I have received a copy of this offices' NOTICE OF PRIVACY PRACTICES.

______________________________ ______________________________ ______________________________
Patient Signature Printed Name Date

If you are signing as a representative, documentation for your legal right to do so must be provided.

______________________________ ______________________________
Personal Representative Date

______________________________ Relationship to Patient

Acknowledgement not obtained because:

☐ Patient refused to sign

☐ Other ______________________________

______ /______ /__________ By: ______________________________

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL FROM MEDICAL PROVIDERS

I authorize Roseville Cardiology to release any and all medical records concerning my care to any Physician, Hospital or other health care professional providing care to me at any time. I also authorize Roseville Cardiology to release any and all medical record concerning my care to Medicare, Medicaid, any insurance company, third party administrator, or managed care company.

Patient Signature ______________________ Date ______________

Printed Name ______________________ Date of Birth ______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

In accordance with Federal Government privacy rule implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individual that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or you are unable to give your authorization due to the severity of your medical condition the law stipulates that these rules may be waived.

_______ I do not authorize Roseville Cardiology to release any or all information concerning my medical care to any individual except as set forth above.

_______ I authorize Roseville Cardiology to verbally release any or all information concerning my medical to the following individuals.

Name ______________________ Relationship to Patient ______________

Name ______________________ Relationship to Patient ______________

Name ______________________ Relationship to Patient ______________

Name ______________________ Relationship to Patient ______________

Patient Signature ______________________ Date ______________

Witness ______________________ Date ______________

Roseville Cardiology

AUTHORIZATION OF RELEASE

PATIENT NAME: ____ **AUTHORIZATION FOR RELEASE**

BIRTHDATE: ____ **OF HEALTH INFORMATION**

FOR OFFICE USE ONLY

I authorize: ____

Name of person and/or facility, which has information

____

Street Address, City, State, and Zip Code

****

Please specify the health information you authorize to be released:

Type(s) of health information: ____

Date(s) of treatment: ____

Persons to whom information may be disclosed
Information described above may be disclosed to:

____

Name of Person or Organization

____

Address & Phone No.

Expiration Date of Authorization
Unless otherwise revoked, this Authorization expires __________ (insert applicable date of event). If no date is indicated, the Authorization will expire 12 months after the date of signing this form. The Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

______________________________ ______________________________

Printed Name Signature of patient, or representative

______________________________ ______________________________

Date Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)