Coastal Cardiovascular Institute

Michael D. Moran, M.D., F.A.C.C., F.S.C.A.I.

Date: ____/____/____ Sex: ____ Male ____Female

Last Name:_____First:_____M.I.:____Age:____ D.O.B.:____/____/_____

Driver's License: (state) _____ (number) _____ SSN: _____-_____-_____

Address: _____ City:_____ST:_____Zip:_____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Work Phone: (____)____-_____

EMAIL ADDRESS:_____@_____

Employer: _____ Occupation: _____

Work Address: _____

Spouse's Name: _____ D.O.B.:____/____/_____ SSN: _____-_____-_____

In case of emergency, contact: _____ Relationship: _____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____Work Phone: (____)____-_____

Referred By:_____Primary Physician:_____Phone: (____)____-_____

Allergies to Medications:_____

Primary Insurance: _____ Insured: ___self ___spouse ___dependant ___other

Subscriber Name (**if not Self**): _____

Subscriber SSN (**if not Self**):_____-____-_____ Subscriber D.O.B. (**if not Self**):____/____/_____

Group #: _____ I.D. # _____ Phone #: (____)____-_____

Secondary Insurance: _____ Insured: ___self ___spouse ___dependant ___other

Subscriber Name (**if not Self**):_____

Subscriber SSN (**if not Self**):_____-____-_____ Subscriber D.O.B. (**if not Self**):____/____/_____

Group #: _____ I.D. # _____ Phone #: (____)____-_____

- As a courtesy to you, we will bill your insurance company for office and hospital professional fees. **Should your insurance company refuse to pay for services rendered, you shall be responsible for the un-applied balance.**
- **Any co-pays or deductibles are due at the time services are rendered.**
- You agree to release any medical or other information necessary to process insurance claims. You further authorize payment of medical benefits to be paid directly to Michael D. Moran, M.D., Inc.

Patient/Guarantor Signature: _____ Date: ____/____/_____

25301 Cabot Road, Suite 104 • Laguna Hills, California 92653
Phone: (949) 297-8167 Facsimile: (949) 297-8350
WWW.HEARTREPAIR.COM

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to any treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS;
CREDIT CARD PAYMENTS WILL INCUR AN ADDITIONAL 3% BANK PROCESSING FEE.
WITH PRIOR APPROVAL, WE CAN ARRANGE A PAYMENT PLAN.

1. As a courtesy to our patients, we will accept assignment of insurance benefits of insurers with whom we are contracted; however, we do require payment of any uncovered portion, such as deductibles and co-payments, to be paid at the time of service. Please do not request discounts, as waiving of co-pays and deductibles is in violation of our contracts and is considered insurance fraud and we can be fined or disenrolled from your insurer for doing so.
2. For visits that we bill, we cannot bill your insurance unless you provide us with your ***current*** insurance information. Some insurers only provide a short window of time to submit claims on your behalf. If we do not have your current insurance information and we submit charges to the company you last provided us with and the charges are denied by your current insurer for "timely filing", you will be financially responsible for 100% of these charges, no discounts will be applied.
3. Patient statements are mailed out every 30 days. It is your responsibility, after the first statement is received or prior arrangements have been made, to contact this office if you feel your bill is incorrect or if you cannot afford to pay at that time to set up payment arrangements. Un-paid balances or lack of attempt to make payment arrangements will be charged a rebilling fee of 5% interest per 30 day billing cycle.
4. It is your responsibility to know your insurance contract's policy provisions, deductibles and limitations.
5. **Out Of Network Plans.** In cases when we are not providers for your insurance, your visit will be an Out-Of-Network service which you will be personally responsible for. Your insurance may impose a deductible and higher copayments than if you received services from a provider in your network. If you do not have Out-Of-Network benefits, you are personally responsible for the full amount of the charges payable upon demand. You are personally responsible for all deductibles and copayments required under your benefit plan and 100% of unpaid charges denied in whole or in part by your insurance.
6. Scheduled surgical procedure deposits, based on your insurance allowable, shall be payable prior to your procedure being performed.
7. Limited records will be copied for you at the time of your appointment, extensive medical records requests are subject to a clinical preparation fee of $25.00 and the California allowable rate of $0.25 per page copying fee.

INITIALS_____

Financial Responsibility

1. All patients are responsible for payment of any unmet patient balances and deductibles/co-pays at the time of service.
2. Financial arrangements are available to our patients, but must be made prior to treatment or upon receipt of statement when the balance cannot be immediately paid in full. Such financial agreements are a commitment on your part as well as ours.
3. Patient or guardian of patient is financially responsible for fees not covered by their insurance. Method of payment could be: Cash, Check or Credit Cards (Credit Cards are charged an additional 3% processing fee): to be provided at time of service. A fee of $35.00 will be charged for returned checks and we will be unable to accept your checks for any services thereafter.

INITIALS_____

Missed Appointments

Your appointment is time which has been set aside for you with the doctor and other patients may have had to wait longer to see the doctor because you were scheduled for this time slot. Unless cancelled at least 24 hours in advance, our policy is to charge for missed consultations or appointments at the rate of $50, and office procedures such as stress/echocardiograms at $150, without exception, unless it is due to a valid emergency. Help us serve you better by keeping scheduled appointments. While we do our best to provide a **courtesy** reminder of your appointment, this is a **courtesy** and it is your responsibility to keep track of your scheduled appointments.

INITIALS_____

If it becomes necessary to utilize an outside collection agency to collect a past due balance, a fee of 30% of the total unpaid balance will be added to cover the costs of collections, any courtesy adjustments or discounts will be reversed and the patient/physician relationship will be terminated.

INITIALS_____

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. **I have read the financial policy and understand and agree to this financial policy.**

Signature of patient/responsible party	Date	Printed name of patient/responsible party
_____	_____	_____

CONSENT FOR ELECTRONIC COMMUNICATIONS WITH DR. MORAN'S OFFICE VIA TEXT MESSAGES AND EMAILS

I request, by my signature below, to allow communication between myself and the staff of Dr. Moran's office via electronic communications, either by text messaging or by email correspondence. I am fully aware that this method of communication is not of a secure nature and I authorize Dr. Moran and his staff to communicate in this manner should the need arise. Should there be any breach of security of the airwaves, text messages sent or received, or emails sent or received between myself and Dr. Moran's office, I will hold Dr. Moran and his staff harmless from any action that such breach precipitates. I make this request and authorization freely and voluntarily and also state that I or Dr. Moran's office may cease and terminate this request at any time by informing the other party of such termination. It is understood that this method of communication is ***not*** intended to be used for routine matters, such as scheduling appointments, requesting prescription refills or other matters that can be handled by contacting your pharmacy or the office directly. Such things as appointment reminders, emailing testing requests (labs, xrays, etc.) or sending patient results is the sole purpose of this method of communication. This agreement only applies to the physician/client relationship, and shall not be extended to family members or friends. Furthermore, text messaging and emailing will only be responded to during normal business hours.

_____ Michael D. Moran, M.D., Inc.

Printed Name

_____

Signature

Date of Birth: _____/_____/_____

Email address: _____@_____

Cell Phone Number: (_____) _____-_____

Michael D. Moran, M.D., F.A.C.C., F.S.C.A.I.

Fellow of the American College of Cardiology

Fellow, Society of Cardiovascular Angiographers and Interventionalists

Diplomate American Board of Internal Medicine

Diplomate American Board of Cardiology

Diplomate American Board of Interventional Cardiology

To: _____ Date: _____

Custodian of Records for: _____

Medical Record Number (if applicable): _____

To Whom It May Concern:

I hearby authorize and request the release of a copy of all medical records, including any x-ray films, catheterization lab, cine angiographic films, written documentation pertaining to any and all previous visits or hospitalizations, cardiology procedure films, and any other items specifically listed below required, be released to my treating physician, Dr. Michael Moran, located at 25301 Cabot Rd., Ste. 104, Laguna Hills, CA 92653, immediately. I trust that you will comply with this request in an expeditious manner.

Other specifically requested items:

_____

_____

_____

Thank you for your prompt attention in the matter,
Sincerely,

_____ _____

Original Signature Witness, DPA or Guardian

_____ _____

Printed Name Printed Name

_____ _____

Date Signed Date Signed

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ 8/1/2018

Physician's or Authorized Representative's Signature (Date)

MICHAEL D. MORAN, M.D.

Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____

Patient's or Patient Representative's Signature (Date)

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(9-13)