Shaoulian Cardiology

320 Superior Avenue, Suite 250 Newport Beach CA 92663

P: 949-631-6144 F: 844-274-0106

PATIENT REGISTRATION FORM

Today's Date: [Date]	Email Address:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? Yes No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: M F

Address/City/State/Zip:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Person who referred you: Doctors Name:______________________________ Persons Name:______________________________	If no referral, how did you learn of our services?

Primary Care Physician (PCP):	Address:	Phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Best Phone no.:
Is this person a patient here?	Yes No	Is this patient covered by insurance?	Yes No
Employer:	Occupation:	Employer address:	Employer phone no.:

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

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 [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

*Effective January 1, 2019, there will be a $50.00 charge for each office visit appointment that is not cancelled within 24 hours and up to a $300.00 charge for all testing appointments that are not cancelled within 24 hours prior to the scheduled time. *Please read Appointment Cancellation Policy and Agreement enclosed.*

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Your signature below is acknowledgment that you have read our HIPPA Notice of Privacy Practices:

Print Name: ____

Signature:____

Date:____

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320 Superior Avenue Suite 250
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Appointment Cancellation Policy and Agreement

Dr. Emanuel Shaoulian is dedicated to treating patients with the personal attention, respect and professionalism they deserve.

Our office informs and educates patients; therefore, it is vital that our patients develop a comforting and trustworthy relationship with us in order to receive the best care possible. When a patient fails to keep and appointment or cancels without timely notification, professional time goes unused and other patients are not provided the care they too deserve. My staff will contact the patient 24 hours in advance from the scheduled appointment for confirmation.

In order to provide effective and efficient treatment to all our patients it is the policy of Dr. Shaoulian that all appointment cancellations are made at least 24 hours prior to your scheduled appointment time. ***Please contact us as soon as possible at: 949-631-6144 if you need to cancel***.

If a patient fails to show up to their scheduled appointment of cancel without 24 hours' notice, Dr. Shaoulian will bill the patient a $100 fee for New & follow-up visits, $100 for echocardiograms or stress treadmill tests & $300 for nuclear stress & lexiscan tests. Insurance will not cover charges for no show or late cancellations. This fee will not be billed to your insurance company.

If you believe there was an error in scheduling or you were unable to cancel within the 24-hour window due to circumstances beyond your control, you have the right to petition the fee by contacting my staff. Your request will be reviewed, and you will be notified of our decision.

By signing below, you agree and understand to the terms set forth in this policy and agreement. You also permit Shaoulian Cardiology Inc. and or Dr. Emanuel Shaoulian to process a charge to the card you provide below in accordance with these terms.

Patient, Parent or Guardian Signature _______________ Date _______________

Patient Name (Please Print) _______________

Credit Card # _______________

Date of Expiration: _______________ CVV: _______________

Billing Address _______________

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Medical Record Release Form

Patient Name:______________________________ Date of Birth:__________________/__________

Last four numbers of Social Security: ____ ____ ____ ____

I, ____ hereby authorize: (previous Physician's name, Hospital, Etc.)

____

Contact Number:___________________________ Fax:_______________________________________

Email Address:______________________________

I hereby authorize and request you to release my medical information to:

Emanuel Shaoulian, M.D. F.A.C.C. and or Shaoulian Cardiology Inc.
320 Superior Avenue Suite 250
Newport Beach, CA 92663
FAX: 844-274-0106 E: Shaouliancardiology@gmail.com

The complete medical records in your possession pertaining to my conditions/or illness including but not limited to:

- ☐ Last Follow up Note(s)
- ☐ Initial Evaluation
- ☐ Last Stress Test /Stress Echo/Stress Nuclear
- ☐ Last Echocardiogram
- ☐ Last ECG
- ☐ Last Lab(s)
- ☐ Last Cardiac CT or CA Score
- ☐ Carotid Ultrasound

Patient Signature:_____________________________________

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Our Privacy Practices and Your Rights

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 action in reliance on the use or disclosure indicated in the authorization.

Your 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 civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 protected 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 us 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 have 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 a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we 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.

Complaint. You may complain to us or to the Secretary of Health and Human Services if you believe that your rights have been violated by us. You may file a complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **01/01/2019.**

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 protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or at our main phone number.

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HIPPA 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.

PERMITTED USES AND DISCLOSURES
We can use or disclose your PHI for purposes of treatment, payment, and health care operations. For each of these categories of uses and disclosures, we have provided a description and examples below. However, not every particular use or disclosure in every category will necessarily be listed.

• **"Treatment"** means the provision, coordination, or management of your health care, including consultations between health care providers, including with skilled nursing, assisted living, short-term rehabilitation, hospital, and other long-term care providers, relating to your care and referrals for health care from one health care provider to another. For example, an attending physician at the skilled nursing facility where you reside treating you for diabetes may need to know if you have a psychiatric disorder or
are taking psychotropic medications because such disorders or medications may have disease-disease or drug-disease interactions with diabetes. In addition, the physician may need to contact another provider for purposes of treating aa psychiatric disorder or condition when our providers are not available to provide your care.

• **"Payment"** means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, claims management, determinations of eligibility and coverage, collections, case management, and other utilization review activities. For example, we may need to provide PHI to your insurance carrier or a party financially responsible for your care in order to determine whether the proposed course of treatment will be covered, to determine appropriate reimbursement, or to obtain payment. Federal
or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

• **"Health Care Operations"** means the support functions for our practice and providers, related to referral, facilitating the telemedicine connection and visit, care coordination, compliance reviews, compliance programs, treatment and payment, quality assurance activities, receiving and responding to patient comments and complaints, provider training, audits, business planning, development, management, legal, and administrative activities. For example, we may use your PHI to evaluate the performance of our provider staff when caring for you. We may also combine PHI about many patients to make clinical qualitative review decisions or decide what additional services we should offer, what services are not needed, and whether certain treatments are effective. We may also disclose PHI for review and educational purposes. In addition, we may remove, or deidentify, information that identifies you so that others can use the de-identified information to study health care, conduct research, collect population health data, and determine methods for improved health care delivery without learning who you are.

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; as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation, and Inmates.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required y the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.