THE CARDIOVASCULAR CENTER

Today's Date:	Family Doctor:

PATIENT INFORMATION

Last name:	First:	MI:	SSN:

Birth date:	Age:	Sex: ◯Male ◯Female	**EMAIL ADDRESS:**

Physical Address: City: State: Zip:

Both required if applicable

Mailing Address: City: State: Zip:

Marital Status:	Home phone #:	Cell phone #:
◯ Employed ◯ Retired	Employer:	Employer phone:
	Occupation:	

Whom may we thank for referring you to our office?

INSURANCE INFORMATION

Primary Insurance Company: ◯ Medicare ◯ Medi-CAL/Partnership ◯ Worker's Comp ◯ Private Insurance

Insurance Name:	Subscriber Name:	Birth date:	Policy ID:	Group #:	Co-pay $:

Secondary Insurance Company: ◯ Medicare ◯ Medi-CAL ◯ Other

Secondary Insurance Name (if applicable):	Subscriber's name:	Policy ID:	Group #:

Secondary Subscribers Employer: Subscribers DOB:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work/Cell phone:

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 authorize The Cardiovascular Center to release any/all of my information to my insurance company(s) required to process my claims.

Patient/Guardian signature:	Date:
If signed by someone other than patient, what is your relationship?	

Personal Representative Authorization for Medical Release Form

I authorize Mohamed H. Khan, Inc. and staff to disclose and/or speak to the following family members or my personal representatives listed below regarding all medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form at any time. I must notify Mohamed H. Khan, Inc., in writing regarding termination and effective date. This authorization shall remain valid until revoked in writing. I am entitled to receive a copy of this agreement.

Signature: _____ Relationship: _____

Printed Name of Patient: _____ Date: _____

Witness: _____ Date: _____

HIPAA Notice of Privacy Practices

THE CARDIOVASCULAR CENTER
2425 SONOMA STREET REDDING, CA 96001
530-241-1144

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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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 condition and related health care 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 of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care 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 health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

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

Healthcare 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, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 purposes 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 your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 have the right to request an amendment to 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 – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

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

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my health care, Mohamed H. Khan, Inc., originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Mohamed H. Khan, Inc. *Notice of Privacy Practices* provides a complete description of the uses and disclosures of my health information. I understand that as part of my care and treatment, it may be necessary to provide my Protected health information to another covered entity. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

I understand this information serves as:

- ♦ A basis for planning my care and treatment
- ♦ A means of communication among the health professionals who contribute to my health care
- ♦ A source of information for applying my diagnosis and surgical information to my bill
- ♦ A means by which a third-party payer can verify that services billed were actually provided
- ♦ A tool for routine assessing the competence of health care professionals

Consent to the Use and Disclosure of Protected health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- ♦ I have the right to review Mohamed H Khan, Inc. Notice of Information Practices prior to signing this consent
- ♦ That Mohamed H. Khan, Inc., reserves the right to change the Notice of Information and that prior to implementation will mail a copy of any revised notice to the Address I have provided if requested
- ♦ I have the right to object to the use of my health information for directory purposes
- ♦ I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Mohamed H. Khan, Inc., is not required by law to agree to the restrictions requested
- ♦ I may revoke this consent in writing at any time, except to the extent that Mohamed H. Khan, Inc., has already taken action in reliance thereon.

Signature: _____ Relationship to Patient: _____

Printed Name of Patient: _____ Date: _____

Witness: _____ Date: _____

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

FOR OFFICE USE ONLY, Please Leave Blank

I hereby authorize: _____ (Name of facility or Dr.)

_____ (City, State, Zip Code)

Phone: _____ Fax: _____

to release the following information for continuance of care to:

The Cardiovascular Center

Mohamed Khan MD
Aazib Khan MD
Allyson Martin PA-C
Cathy Ludlow FNP

2425 Sonoma Street, Redding CA 96001
(530) 241-1144
(530) 241-1142 fax

Please send ONLY the following:

- **-Ekg with tracings**
- **-Most recent chart note**
- **-History and Physical**
- **-Cardiac/Vascular Procedures**
- **-Chest X-rays**
- **-Discharge Summary**
- **-ER report**
- **-Most recent Labs**
- **-Studies such as echocardiogram, stress test, vascular studies, CT scans**

_____ **Please respond if no records are available for this patient**

This authorization is subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

I understand that the recipient may not lawfully further use or disclose the Protected Health Information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. If this authorization is not revoked by the patient or responsible party, it will remain valid indefinitely.

Signature: _____ Relationship to patient: _____

Witness: _____ Date: _____

FINANCIAL POLICY

The Cardiovascular Center is committed to providing high quality care to all our patients. We are participating providers with most insurance plans and will submit claims to your insurance company on your behalf. As a courtesy we will work with your insurance company to ensure that you receive all benefits due to you. However, most insurance plans do not pay 100% of the claim and the unpaid, allowable balance is the responsibility of the patient.

Patients who have medical insurance should be aware that charges for services rendered are the responsibility of the patient, not the insurance company. It is your obligation to know the terms of your insurance coverage and to provide the practice with all the correct information necessary to process a claim. If the correct insurance information is not presented to our office by the patient, the patient is responsible to pay the balance of the account.

Co-pays, Medicare co-ins and deductibles are collected at the time of service. If you are unable to meet your financial obligations, you may be asked to reschedule.

*****A $50.00 - $200.00 fee will be charged for all missed appointments or failure to cancel within 24 hours of your appointment time. *****

Patients who do not have insurance are expected to pay at the time of service. We accept cash, check, and credit/debit.

Prompt payments are appreciated and accounts will be addressed based on your individual needs. Regular payments are required or the account will default to collections. Once your account is transferred to our collection agency, we cannot participate in your care until the balance is paid in full.

By signing below, I understand the above information and authorize The Cardiovascular Center to submit claims on my behalf to my insurance company.

Patient Name_____

_____ _____

Patient/Representative Signature Date

Revised 04/04/2022

2425 Sonoma Street | Redding, CA 96001 | Phone 530.241.1144 | Fax 530.241.1142

PATIENT TERMINATION POLICY

The Cardiovascular Center Providers and staff strive to create a pleasant environment. We understand that there are times when you may be frustrated due to your current symptom(s) or personal situations. We will make every attempt to help you; however, this practice, under no circumstances will tolerate:

* Verbal/physical abuse to staff or providers
* Repeated failure to show for appointments
* Nonpayment of outstanding account balances
* Failure to comply with payment arrangement agreement

Any above violation of the above or abuse is grounds for dismissal from the practice.

Print patient name: _____ Date: _____

Patient Signature: _____

THE CARDIOVASCULAR CENTER
SERVING TO IMPROVE THE QUALITY OF EVERY HUMAN LIFE
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