INLAND VALLEY CARDIOLVASCULAR CENTER
Hoang M. Lai, M.D.
REGISTRATION FORM

PATIENT INFORMATION

Patients Name: _____
Last Name **First Name** **D.O.B** **AGE** **Sex: M F**

Patient Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Home Number:** _____

Must have patient SSN# for billing purpose #: _____ **Cell Number:** _____

Responsible Party (if minor)*:** _____ ***Relation to patient: _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Employer: _____ **Contact Person:** _____ **Work #:** _____

Employer Address: _____ **City:** _____ **State:** _____

Referring Physician or Person: _____

SPOUSES INFORMATION

Spouses Name: _____
Last Name **First Name**

Spouses SSN#: _____ **Birthdate:** _____ **Cell Number:** _____

Employer: _____ **Contact Person:** _____ **Phone #:** _____

Employer Address: _____ **City:** _____ **State:** _____

INSURANCE INFORMATION

Are We Billing Insurance? Yes No If so, whom is the *SUBSCRIBER* of your insurance?
Subscriber Name: _____ **Subscriber D.O.B.** _____ **Subscriber SS#:** _____

Name of Primary Insurance:
_____

Name of Secondary (if any): _____

I give the physicians and office staff of Hoang Lai, M.D. permission to discuss my medical condition with the following family members/friend:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

PLEASE INITIAL ALL THAT PERTAINS TO THE PATIENT

PLEASE INITIAL SPACES BELOW

I authorize the release of any Medical Information to process claims. _____

I authorize the release of payment for Medical Benefits to Hoang Lai, M.D. _____

I hereby consent to and authorize the performance of all treatments, surgery, and medical/behavioral health services by the staff of Brian Bui which they may deem advisable. I hereby certify that to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. _____

I furthermore agree to pay legal interest, collection expense, and attorney's fees incurred to collect any amount I may owe. I also hereby authorize Hoang Lai, M.D. to release information requested by my insurance company and/or its representatives. _____

I authorize Hoang Lai, M.D./staff to leave messages on my answering machine regarding appointments and test results. _____

CONSENT FOR PHOTOGRAPHY

I authorize Hoang Lai, M.D. to photograph me and/or my medical condition for my electronic medical records. This photograph may be used for used for educational purpose or medical research with my consent. _____

I hereby acknowledge the HIPPA (privacy practices) notice from Hoang Lai, M.D. is available upon request.

Signature: _____

MEDICARE ONLY

I certify that I am not a member of any captivated Health Maintenance Organization (HMO), such as Secure Horizons, Blue Cross Senior, or Scan. I further understand that membership in such a program prevent Medicare from covering my expenses for services provided by Hoang Lai, M.D. and that I would be fully responsible for those uncovered charges. _____

I request that payment of authorized Medicare benefits be made to Brian Bui. I authorize any holder of medical information about to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable to relate service._____

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown._____

With Medicare assigned cases, Hoang Lai, M.D. agrees to accept the allowed amount determined by Medicare and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the allowed amount by the Medicare carrier. _____

_____ Date: _____
Signature of Patient

SIGNATURE

_____ Date: _____
Print Full Name

_____ Date: _____
Signature of Patient or Guardian

INLAND VALLEY CARDIOVASCULAR CENTER

Office Policy

Hoang M. Lai, M.D.

- THERE IS A 25.00 CANCELLATION FEE IF NOT CANCELLED WITHIN 24 HOURS.
- YOUR APPOINTMENT MAY BE RESCHEDULED IF YOU ARRIVE MORE THAN 15 MINUTES LATE TO YOU SCHEDULED APPOINTMENT TIME.
- ANY VOICEMAILS LEFT BEFORE 11AM WILL BE RETURNED ON THE SAME BUSINESS DAY, ANY VOICEMAILS LEFT AFTER WILL BE RETURNED THE NEXT BUSINESS DAY. (WITH SOME EXCEPTIONS)
- THERE IS 72 HOUR TURN AROUND FOR ALL PRESCRIPTIONS REFILLS! ** IF YOU NEED A PRESCRIPTION REFILL, PLEASE CALL YOU LOCAL PHARMACY AND REQUEST YOUR REFILL.
- THERE WILL BE A 15.00 FEE ON ALL PERSONAL PAPERWORK COMPLETED BY OUR PHYSICIAN (DMV FORMS, EDD FORMS, ECT.) PLEASE ALLOW 72 HOURS FOR ALL FORMS TO BE COMPLETED.
- THERE WILL BE A REASONABLE CLERICAL FEE AS WELL AS $.25 PER PAGE FOR COPYING YOUR MEDICAL RECORDS. CLERICAL FEES FOR SUBPOENAS ARE LIMITED TO $15 IF A PHOTOCOPY SERVICE IS PROVIDED.

AS OUR OFFICE CONTINUES TO GROW, WE HAVE TO ENFORCE POLICIES THAT WILL BENEFIT OUR OFFICE AS WELL AS THE PATIENT WE SERVE.

THANK YOU FOR YOU UNDERSTANDING AND WE WELCOME YOU TO OUR OFFICE.

Patient Signature: Date:

PRIVACY POLICY STATEMENT

INLAND VALLEY CARDIOVASCULAR CENTER

Hoang M. Lai, M.D.

39755 MURRIETA HOT SPRING RD. SUITE E-130 MURRIETA, CA 92563

PRIVACY OFFICER: SHELLY STEPHENS OFFICE MANAGER

PURPOSE:

The following privacy policy is adopted to ensure that this medical practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.

Effective Date: 9/1/2013

It is policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPPA and California Law.

Notice of Privacy Practices:

It is the Policy of this medical practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this medical practice to post the most current notice of privacy practices in our "waiting room" area, and to have copies available for distribution at our reception desk.

Assigning Privacy and Security Responsibilities:

It is the policy of this medical practice that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPPA Privacy and Security Rule's requirements. Furthermore, it is the policy of this medical practice that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of this medical practice that there will be one individual or job description designated as the Privacy Official.

Deceased Individuals:

It is the policy of this medical practice that privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information:

It is the policy of this medical practice that for all routine and recurring uses and disclosures of PHI (except for uses or disclosure made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPPA compliance such uses and disclosures of protected health information must be

limited to the minimum amount of information needed to accomplish the purpose of the uses or disclosure. It is also the policy of this medical practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request their rights under HIPPA regulations. It is also the policy of this organization that no employee or contractor may condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information except as, expressly authorized under the regulations.

Responsibility:

It is the policy of this medical practice that the responsibility for designing and implementing procedures to implement procedures to implement this policy lies with the Privacy Official**.**

Verification of identity:

It is the policy of this medical practice that the identity of all persons who request access to protected health information be verified before such access is granted.

Mitigation:

It is the policy of this medical practice that the effects of any unauthorized use or disclosure of protected health information be mitigated to the extent possible.

Safeguards:

It is policy of this medical practice that appropriate physical safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPPA Privacy Rule. These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection. These safeguards will extend to the oral communication of PHI. These safeguards will extend to the PHI that is removed from this organization.

Business Associates:

It is the policy of this medical practice that business associates must be contractually bound to protect health information to the same degree as set forth in this policy. It is also the policy of this organization that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

Training and Awareness:

It is the policy of this medical practice that all members of our workforce have been trained by the compliance date on the policies and procedures governing protected health information and how this medical practice complies with the HIPPA Privacy and Security Rules. It is also the policy of this medical

practice that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is the policy of this medical practice to provide training should any policy or procedure related to the HIPPA Privacy and Security Rule materially change. This training will be provided within a reasonable time after the policy or procedure materially changes. Furthermore, it is the policy of this medical practice that training will be documented indicating participants, date and subject matter.

Acknowledgement of Receipt of Notice of Privacy Practices

Hoang M. Lai, M.D.

Privacy Officer: Shelly Stephens (951) 894-1131

I hereby acknowledgement that I received a copy of this medical practice's Notice of Privacy Practices, I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by E-mail at:

Signed: Date:

Print Name: Telephone:

If not signed by the Patient, Please indicate relationship:

◯ Parent or guardian of minor patient

◯ Guardian or conservator of an incompetent patient

Name and Address of Patient:

Inland valley Cardiovascular Center

Brian A. Bui, M.D., F.A.C.C.
Steve Hui Jin, M.D., F.A.C.C., F.S.C.A.I.
Hoang Lai, M.D.

Health and Clinical History

Please take the time to complete this form as it will enable the physician to best assess your current medical status and provide the best course of care. If you do not know the answer to a question, or you are unsure, please insert a question mark in the corresponding space.

Name: (Last, First and Middle)

Telephone Number: Date of Birth: Age:

Referring Physician: Marital Status:

Reason for Seeing the Physician:

Cardiovascular History

Please check and date any of the following that applies to you:

	Date	Location (city/State)
_____Myocardial Infarction (heart attack)	_____	_____
_____Hearth Catherization/Angiogram	_____	_____
_____Angioplasty and/or Stents	_____	_____
_____Coronary Artery Bypass Surgery	_____	_____
_____Stress Test	_____	_____
_____Echocardiogram (ultrasound)	_____	_____
_____Holter/Event Monitor	_____	_____
_____Pacemaker/ICD/Loop Recorder Implant	_____	_____
_____Arrhythmia	_____	_____
_____Other Cardiac Procedure	_____	_____

Name: _____

Cardiovascular Risk Factors

Please check and complete the following that pertains to your history/lifestyle:

_____ Smoking History – Do you smoke? _____ Date you quite: _____

_____ How many years did you smoke? _____ How many packs per day? _____

_____ High blood pressure – For how long? _____ Treatment: _____

_____ High cholesterol – what was your last result? _____

Have you ever been treated with medication for your cholesterol? _____

What medication(s)? _____

_____ Rheumatic fever– At what age? _____

_____ Rheumatic heart disease – At what age? _____

_____ Congenital heart disease – At what age? _____

_____ Heart Murmur – First diagnosed when? _____

_____ Chest discomfort – How frequent and when? _____

With exercise? _____ At Rest? _____

_____ Palpitations

_____ Passing out (Syncope)

_____ Shortness of breath on exertion

_____ Shortness of breath requiring two (2) or more pillows for comfortable sleep

_____ Waking at night, short of breath

_____ Unusual fatigue

_____ Previous leg vein stripping procedure

_____ Phlebitis

_____ Swelling in the ankles or legs

_____ Leg discomfort with walking. How far can you walk before you get pain? _____

_____ Diabetes Mellitus – When was it diagnosed? _____ Type I or Type II? _____

Name: _____

_____ Family history of heart disease – who and what type? _____

_____

_____ Are you regularly un-refreshed, even after waking from a full night's sleep?

_____ Do you fall asleep easily during your waking hours at home or work?

_____ Are you a loud, habitual snorer?

_____ Have you been observed choking, gasping or holding your breath during sleep?

_____ Have you ever had a sleep study? If yes, when? _____

_____ Do you often suffer from poor concentration or judgment, memory loss, irritability and or depression?

_____ Are you currently on a special diet plan? If so what type: _____

_____ Do you regularly exercise three (3) times a week or more?

If so, what type of exercise are you doing? _____

What is the most vigorous physical activity you perform? _____

What was your weight at 21? _____

Current Medications

Please provide vitamins and supplements as well

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____

Allergies

Please list any drug allergies and the type of reaction that occurs

_____
_____
_____

_____ Do you have asthma? _____ COPD _____ Emphysema

_____ Do you use daily inhalers? If yes, please list: _____

Past Medical & Surgical History

Please provide past hospitalizations and surgeries

Reason	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Health History & Symptoms

Please check any of the following that applies to your history

_____ Pleuritic pain	_____ Pancreatitis	_____ Menstrual dysfunction
_____ Blood clots	_____ Ulcer	_____ Arthritis
_____ Pneumonia	_____ Broken bones	_____ Emphysema
_____ Thyroid disease	_____ Anxiety or depression	_____ Stroke
_____ Skin problems	_____ Gout	_____ Anemia
_____ Gallstones	_____ Hepatitis	
_____ Difficult/painful urination	_____ Libido/erection difficulty	

Name: _____

Social & Personal History

How many children? _____ What are their ages? _____

How long at your current address? _____ Occupation? _____

Where were you born? _____

What is your highest level of education? _____

Family History

Please indicate the health status of each of the following members and state their age. If deceased, please indicate cause and appropriate age.

Father: _____

Mother: _____

Brother(s)/Sister(s): _____

Children: _____