INLAND VALLEY CARDIOVASCULAR CENTER

Brian A. Bui, 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 Brian A. Bui, 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 Brian A. Bui, 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 Brian Bui, M.D. to release information requested by my insurance company and/or its representatives. ___________

I authorize Brian Bui, M.D./staff to leave messages on my answering machine regarding appointments and test results. __________

CONSENT FOR PHOTOGRAPHY

I authorize Brian Bui, 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 Brian Bui, 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 Brian Bui, 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, Brian Bui, 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

PATIENT FINANCIAL RESPONSIBILITIES

Co-Payment and Deductible

You are responsible to provide payment for your deductible and co-payment and any non-covered services received . If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied and/or eligibility verification of your plan indicates your coverage is no longer effective, payment is required at the time of service. Your co-payment is also due at the time of service.

Medicare

We do accept Medicare assignment. You are responsible for your deductible and co-payment. If you have a secondary insurance carrier, a portion of your co-payment may be covered.

Non-Covered Services

If we provide services to you that are not covered by your health plan or you are not a covered enrollee under the plan at the time the services in question were rendered, you will be responsible for payment in full for those services. Your signature below constitutes agree to pay for such services.

Payment Arrangements

Payments may be made in cash, by check or credit card. Payment is expected at the time of service, payment arrangements will not be granted.

We are happy to discuss with you any questions relating to the information above. We thank you for choosing Inland Valley Cardiovascular Center for your cardiovascular care.

Patient Signature: ______________________________ Date: ___________________

Print Name: ___________________________________

INLAND VALLEY CARDIOVASCULAR CENTER

Office Policy

Brian A. Bui, 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

Brian A. Bui, 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: 4/8/2011

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

Brian A. Bui, 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.
Hoang M. Lai, M.D.
Harit V. Desai, 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) ____________ Date of Birth: ____________ Age: ____________

Telephone Number: ____________ Marital Status: ____________

Reason for seeing the physician: ____________

Cardiovascular History

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

	Date	Location (city/town)
_____Myocardial Infarction (heart attack)	________________	____________________
_____Heart Catheterization/Angiogram	________________	____________________
_____Angioplasty or Stents	________________	____________________
_____Coronary Artery Bypass Surgery	________________	____________________
_____Stress Test	________________	____________________
_____Echocardiogram (ultrasound)	________________	____________________
_____Holter/Event Monitor	________________	____________________
_____Pacemaker/ICD Implant	________________	____________________
_____Arrhythmia	________________	____________________
_____ Other Cardiac Procedure	________________	____________________

39755 Murrieta Hot Springs Rd., Suite E-130, Murrieta, CA 92563 (951) 894-1131

Name: ________________________________

Cardiovascular Risk Factors

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

_____ Smoking History – Do you smoke? _______ Date you quit: _____________________________

_____ 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 medications for your cholesterol? _______________________

What medications? ____

_____ Rheumatic fever – At what age? ____

_____ Rheumatic heart disease – At what age? ____

_____ Congenital heart disease – At what age? ____

_____ Heart Murmur – First noted 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 age 21? ____

Current Medications

Please provide vitamins and supplements as well

Medication	Dose	Frequency/Day

Name: ________________________________

Allergies

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

____
____
____

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

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 approximate age.

Father: ____

Mother: ____

Brother/Sister: ____

Children: ____

So that we can assure that your reports get to the appropriate physicians, please provide us with the following information:

____

Referring Physician Name Phone Number Fax Number

____

Primary Care Physician Name Phone Number Fax Number

In the event that you need prescriptions or are prescribed medications with your visit, please provide us with your preferred pharmacy contact information.

____

Pharmacy Name/Address Phone Number Fax Number