SC CARDIOLOGY
MEDICAL CENTER, INC.

27830 Bradley Rd.
Sun City, CA 92586
P: 951-672-3888
F: 951-672-3758

28078 Baxter Rd. Ste.428
Murrieta, CA 92586
P: 951-246-8881
F: 951-246-9300

Patient Information

Patient Name: ____ Date of Birth: _____/______/_________
Last First M.I.

I prefer to be called: ____ Sex: Male or Female

Driver License #: ____ Social Security #: ________/________/___________

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

Address: ____City: __________________ State:________ Zip: ___________

Home Phone: _______________________________________ Cell: ____

Email Adress: ____

Employer: ___________________________________ Work Address: ____

Primary Doctor: ____ Phone Number: ________________________________

Referring Doctor (if different than PCP): ______________________ Phone Number: _______________________________

Spouse or Guardian Name: _______________________________ Phone Number: ______________________________

Preferred Language: ___________________________ Ethnicity: _____________________ Race: Hispanic Not Hispanic

Insurance Information & Responsible Party

Name of Insured: ___________________________________ DOB: ____/____/_______ SS#: _________________________

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other

Primary Insurance Company: ____

Policy ID: ____ Group #: _______________________________________

Secondary Insurance Company (if applicable):____

Policy ID#: ____ Group #: ____________________________________

Assignment and Release

I, the undersigned have insurance coverage with the above listed insurance, and assign directly to **Sun City Cardiology Medical Center, Inc**. all medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of my signature on all insurance submissions.

Patient Signature: ____ Date: ____________________________

Please notify us if any of the above information changes during the course of your treatment.

MEDICATION INFORMATION

SC CARDIOLOGY
MEDICAL CENTER, INC.

PATIENT INFORMATION

Name:	Date of Birth:

Physician(s):	Physician's Phone Number:	Pharmacy:	Pharmacy's Phone Number:

CURRENT MEDICATION REGIMEN

MEDICATION	DOSAGE	FREQUENCY	CONDITION / SPECIAL NOTES

Medical History

SC CARDIOLOGY
MEDICAL CENTER, INC.

Last Name:		First Name:	Middle Initial:
Date of Birth:	Sex:	Weight:	Blood Type:

Allergies	Cardiac	Surgery
O None	O None	O Bypass- Heart ______________
O Penicillin	O Enlarged Heart	O Coronary Angiogram ___________
O Sulfa	O Murmur	O Stents/ PTCA ___________
Other____________________	O Angina	O Heart __________
________________________	O Atrial Fibrillation	O Valve Replacement __________
________________________	O Arrhythmia	O Pacemaker/Defibrillator ________
________________________	O Cardiomyopathy	O Back __________
________________________	O Congestive Heart Failure	O Breast L / R ___________
________________________	O Congenital Heart Disease	O Abdominal ___________
________________________	O Chest Pain	O Gallbladder ___________
________________________	O Numbness	O Hemorrhoids __________
________________________	O Heart Attack	O Lung __________
________________________	O Mitral Valve Prolapse	O Neurological ____________
________________________	O Palpitations	O Prostate __________
	Other__________________	O Tonsils ___________
	______________________	Other________________________
	______________________	

Chronic Illnesses		Transmissible Diseases		Previous Cardiac Testing
		In the last 3 months, have you been in contact with any of the following:		
O None	O Hepatitis	O SARS	O Pnuemonia	O Echocardiogram Date: _________
O Anemia	O Gastrointestinal	O Mumps	O Pertussis	O Treadmill Stress Test Date: _________
O Arthritis	O HIV/AIDS	O Meningitis	O Diptheria	O Nuclear Stress Test Date: _________
O Asthma	O Paralysis	O Rubella	O Pharyngitis	O 24 Hour Holter Monitor Date: _________
O Cancer	O Pneumonia	O Anthrax	O Smallpox	O 30 Day Event Monitor Date: _________
O COPD	O Psychological	O Shingles	O Chicken Pox	O Carotid Ultrasound Date: _________
O CVA / TIA/ Stroke	O Depression	O Measles	O Tuberculosis	O Venous Ultrasound Date: _________
O Diabetes	O Seizures	O Zika Virus	O Ebola	
O High Blood Pressure	O Drug Abuse	O Any type of flu/Influenza		
O Low Blood Pressure	O Unknown	O NONE OF THE ABOVE		
O Kidney Disease	O Tuberculosis	Other:		
O Migraine Headaches	O Dialysis/Renal	______________________		
Other:		______________________		
________________________		______________________		
________________________		______________________		
________________________				
________________________				

O Alcohol Y/ N O Tobacco Past / Present / Never O Caffeine/Coffee/ Tea/ Soda	**Family History** **If Living; Good/Fair/Poor Health & Present Age** **If Deceased; Cause of Death & Age**
Father	1.
Mother	2.
Brothers/ Sisters	3.
Children	4.

Sun City Cardiology Medical Center, Inc.
Bhoodev Tiwari, M.D., F.A.C.C.
Interventional Cardiology & Nuclear Cardiology
Board Certified in Cardiovascular Disease

Sun City Medical Dental Building
27830 Bradley Rd.
Sun City, CA 92586

LLUMC Murrieta Professional Office Building
28078 Baxter Rd. Ste #428
Murrieta, CA 92563

Notice of Hospital Ownership of Investment

This "Notice of hospital ownership or investment" is provided by Bhoodev Tiwari, M.D. in order to assist you in making an informal decision regarding your care. This notice discloses the following information:

- Bhoodev Tiwari, M.D., or an immediate family member of Bhoodev Tiwari, M.D., has an ownership or investment interest in Menifee Valley Medical Center and Hemet Valley Medical Center, and your treating Physicians may also have an ownership or investment interest in Menifee Valley Medical center and Hemet Valley Medical Center.
- Please review the attached list of the Menifee Valley Medical Center and Hemet Valley Medical Center's owners or investors who are physicians. The list of physician owners is also available on the hospitals website at www.physiciansforhealthyhospital.com.
- You are free, however to choose any other provider for the purpose of obtaining the services ordered or requested by your physician (except as your choice may be limited by the terms of your health coverage).
- We value our relationship with you.

THE FOLLOWING PHYSICIANS HAVE AN OWNERSHIP INTEREST IN HEMET VALLEY MEDICAL CENTER AND MENIFEE VALLEY MEDICAL CENTER

Ashok K. Agarwal, M.D.	Chia M. Lee, M.D.	Larry C. Hughes, M.D.	Stanley Schinke, M.D.
Gerard J. Carvalho, M.D.	Chong Ping Lu, M.D.	Abid Hussain, M.D.	Kishore Segal, M.D.
Kali J. Chaudhuri, M.D.	Herman Mathias, M.D.	Vidhya V. Koka, M.D.	Surendra Sharma, M.D.
Han-Min Chiu, M.D.	Amal Mehta, M.D.	Hemchand Kolli, M.D.	David C. Stanford, M.D.
Sanyasi Ganta, M.D.	Chandrakant V. Mehta, M.D.	Renato Judalena, M.D.	Bhoodev Tiwari, M.D.
Neelam Gupta, M.D.	Evelyn F. Mendoza, M.D.	Ratan Tiwari, M.D.	Anil Rastogi, M.D.
Rakesh C. Gupta, M.D.	Sreenivasa Nakka, M.D.	Frederick White, D.O.	Surya Reddy, M.D.C
Miland P. Panse, M.D.	Girdhari Purohit, M.D.	Manikanda Raja, M.d.	

Disclosure of Financial Interest in Medical Facilities

This is to inform you that I have an administrative and/or financial interest in the medical facilities listed below. We would like you to understand that you have a choice, and at your request, you may be referred to a similar facility in which we have no financial interest. Should you so desire, please inform our office staff or the doctor and we will be happy to make other arrangements.

The above disclosure is made in compliance with regulations of the State of California.

Referral Facility (Interest)	**Alternative**
Menifee Valley Medical Center	Loma Linda Medical Center Murrieta
Hemet Valley Medical Center	Rancho Springs Medical Center
	Inland Valley Medical Center
	St. Bernadine's Medical Center

My signature indicates that I have read and understand the above.

Patient Signature: ____

Patient Name: ____ Date: ___________________

Sun City Cardiology Medical Center, Inc.

Sun City Medical Dental Building
27830 Bradley Rd.
Sun City, CA 92586
951-672-3888 Fax: 951-672-3758

LLUMC Professional Office Building
28078 Baxter Rd. Ste. 428
Murrieta, CA 92563
951-296-8881 Fax: 951-246-9300

WWW.SCCMC.COM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Requesting Records From:
(Please provide name of physician, complete address and phone number)

____
____
____
____

Send Records To:

- Bhoodev Tiwari, M.D., F.A.C.C.
- Rahul Gaglani, MD
- Samir Artoul, MD,F.A.C.C.

Fax Records to 951-672-3758

Information to be released is:

_____All Medical Records _____Operative Reports _____Angio/PTCA/Stent/Bypass
_____Lab Reports _____Psychiatric/Drug Abuse _____Nuclear Tests
_____X-Ray Report _____Billing Summary _____Holter
_____Echocardiogram _____Treadmill Stress Test _____Other:______________________

Records Released are authorized for the following purpose:

_____Continued Care _____Personal Care _____Attorney/Legal

_____Insurance _____Other:____

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form in order to receive healthcare treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.
This authorization shall become effective immediately and shall remain in effect until _______________.
If I fail to specify an expiration date, this authorization will expire 1 year from the date of signature.
I understand that I am entitled to a copy of this authorization.

Patient name: ____Date of Birth:_________
Last First M.I.

____ Date:__________
Signature of Patient

Personal Information Consent

I, ____, give the physician and staff of Sun City Cardiology Medical Center permission to discuss my medical condition (s) with the following contacts:

Please be advised that you are allowing our office to discuss your personal information with the contacts listed below. If there is any specific information that you would NOT liked discussed, Please list below:

____

____

____

____

Contacts We Are Allowed To Discuss Information With:

Name: ______________________________________ Phone: _____________________________

Relationship: ____

Name: ______________________________________ Phone: _____________________________

Relationship: ____

Name: ______________________________________ Phone: _____________________________

Relationship: ____

Name: ______________________________________ Phone: _____________________________

Relationship:____

THIS CONSENT FORM IS INDEFINITE UNLESS OTHERWISE SPECIFED

Patient Signature:____ Date:___________

SUN CITY: Sun City Medical/Dental Bldg- 27830 Bradley Rd. Sun City, CA 92586

MURRIETA: LLUMC Murrieta Professional Office Bldg- 28078 Baxter Rd. Suite 428 Murrieta, CA 92563

SC CARDIOLOGY
MEDICAL CENTER, INC.

Sun City Cardiology Medical Center, Inc.

INSURANCE ELIGIBILITY GUARANTEE FORM

I, ____ hereby certify that I am eligible for

___________________________________and ______________________________ Health Plan.

I have chosen **Dr. Bhoodev Tiwari, Dr. Rahul Gaglani, and Dr. Aroul** to be my cardiology care physician.

I request that payment of authorized insurance benefits be made on behalf of **Dr. Bhoodev Tiwari, Dr Rahul Gaglani, and Dr. Samir Artoul** for any services furnished to me by that Physician/Supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim if "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims. My signature authorizes releasing assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or Private/County Insurance carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible is based upon the charge determination of the Medicare or Private/County Insurance carrier.

I understand that if the above is not true or if I am not eligible under the terms of my Medical Health Insurance Agreement, I will be held liable to pay all charges for services rendered. Also, if the above is not true, I agree to contact the medical biller within 30 days of receiving a bill, to make billing arrangements.

If arrangements are made in advance, I agree to pay in full for all services received, within the time limits set forth by the medical biller.

____

Signature of Member (or Guardian) Date

____

Office Personnel (Initial and Date) Date

Medicare Authorization/Assignment of Benefits:

For Medicare patients only

I request that payment of authorized Medicare benefits be made to or on my behalf to **Sun City Cardiology Medical Center, Inc.,** for any services furnished to me by one of its providers. I authorize any holder of information about me to the Centers for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________________________

Patient's Printed Name Medicare ID Number

______________________________ ______________________________

Patient's or Representative's Signature Date

Medi-Gap/Medicare Supplemental Insurance Lifetime Assignment of Benefits I, the undersigned, have Medi-gap Insurance coverage and assign directly to **Sun City Cardiology Medical Center, Inc.,** all benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until evoked by me in writing.

__________________________ ______________________ __________

Signature of Beneficiary Insurance ID number Date

Sun City Medical Dental Building
27830 Bradley Rd.
Sun City, CA 92586

LLUMC Murrieta Professional Office Building
28078 Baxter Rd. Ste #428
Murrieta, CA 92563

OFFICE POLICIES

Appointments

To schedule an appointment, please call our office as far in advance as possible or stop by the reception desk following your office visit. If there is a specific provider you wish to schedule with, be aware that you may need to do so several weeks in advance, upon availability.

We make every effort to have patients seen by their scheduled doctor each visit. However, it may be necessary to see one of your doctor's associates as our doctors are often called to the hospital for emergency care.

We have multiple appointment types available so it is important to state the nature of your visit in order for us to properly place you on the schedule. If you need a cardiac clearance please be sure that you schedule your visit far enough in advance so that there is ample time to schedule any tests and a follow up if needed prior to your procedure.

In order to better serve each and every one of our patients we ask that if you are not able to keep your scheduled appointment please cancel 24 hours in advance so that an appointment is available for the next patient. If you do not show to your scheduled appointment a $25.00 fee may be applied to your account.

If you are an HMO patient please be sure to bring your referral to your appointment. If it is not available then your appointment will be rescheduled until it is provided.

Emergencies and after hour calls

When our office is closed our calls are sent to our answering service. If you have an urgent matter that needs to reach the doctor, the answering service will ask your name, telephone number, and the reason for your call. This information will be forwarded to the physician on call. In the event that there is an emergency please call 911. For all other routine calls please call the office the next business day.

Prescription Requests

When requesting a refill please have your medication name, dose, quantity, how many times taken, and your pharmacy information readily available. We required 24 to 48 hours before your prescription request will be available. We recommend that you call your pharmacy to make sure your prescription is ready.

Our Financial Policy

Before every visit you will be asked to provide your current insurance cards and updated demographic information so that there is no delay in processing your insurance claim. All office co-pays are to be collected at the time of service. We accept checks, cash and credit cards. Credit transactions can only be processed at our office so that a valid ID can be presented.

As a courtesy we will submit your insurance claims on your behalf. However, the agreement between you and your insurance carrier is your responsibility. If you have any complaints pertaining to the amount covered you must contact your insurance agent.

Insurance companies vary in their coverage so it is important that you understand your covered benefits. Patients are responsible for any co-pays, deductibles, or co-insurance amounts. The collectable amounts are outlined in your explanation of benefits sent to us by your carrier.

Payments

All balances are due within 15 to 30 days of the date of service. If you have financial difficulties please notify the billing department so that we can start a payment agreement. If balance remains unpaid a $5.00 fee will be applied to your balance each month that a payment is not received.

____ ___________

Signature **Date**

____ ____________

0Witness **Date**

Bhoodev Tiwari, M.D., F.A.C.C.
Samir Artoul, M.D., FA.C.C.
Rahul Gaglani, M.D.

Interventional, Invasive and Non-Invasive Cardiology

Diplomat of American Board of Cardiovascular Disease & Internal Medicine · Fellow of American College of Cardiology

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, OR HEALTHCARE OPERATIONS (HIPPA)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my 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
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **NOTICE OF INFORMATION PRACTICES** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

- I request the following restrictions to the use or disclosure of my health information: ___________________________

____

______________________________________ Signature of patient or Legal Representation

____________________________________ Witness

_______________________________________ Date

____________________________________ Notice effective date or version

_____________Accepted   _____________Denied

27830 Bradley Road · Sun City, California 92586 · (951)672-3888 · Fax: (951)672-3758
28078 Baxter Road St. 428 Murrieta, California 92586 (951)246-8881 Fax: (951) 246-9300