



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

Patient Demographics

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 Address: _____

Employer: _____ Work Address: _____

Primary Doctor: _____ 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.

|| Bhoodev Tiwari, MD, FACC || || Samir Artoul, MD, FACC || Ali Dabestani, MD, FACC ||

WWW.SCCMC.COM



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

Medical History

Patient Name: _____ Date of Birth: ____/____/____

<p>Allergies</p> <p><input type="radio"/> None Or list them:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Cardiac</p> <p><input type="radio"/> None <input type="radio"/> Enlarged Heart <input type="radio"/> Murmur <input type="radio"/> Angina <input type="radio"/> Atrial Fibrillation <input type="radio"/> Arrhythmia <input type="radio"/> Cardiomyopathy <input type="radio"/> Congestive Heart Failure <input type="radio"/> Congenital Heart Disease <input type="radio"/> Chest Pain <input type="radio"/> Numbness <input type="radio"/> Heart Attack <input type="radio"/> Mitral Valve Prolapse <input type="radio"/> Palpitations Other: _____</p> <p>_____</p> <p>_____</p>	<p>Surgery</p> <p><input type="radio"/> Bypass- Heart _____ <input type="radio"/> Coronary Angiogram _____ <input type="radio"/> Stents/ PTCA _____ <input type="radio"/> Heart _____ <input type="radio"/> Valve Replacement _____ <input type="radio"/> Pacemaker/Defibrillator _____ <input type="radio"/> Back _____ <input type="radio"/> Breast L / R _____ <input type="radio"/> Abdominal _____ <input type="radio"/> Gallbladder _____ <input type="radio"/> Hemorrhoids _____ <input type="radio"/> Lung _____ <input type="radio"/> Neurological _____ <input type="radio"/> Prostate _____ <input type="radio"/> Tonsils _____ Other _____</p>
<p>Chronic Illnesses</p> <p><input type="radio"/> None <input type="radio"/> Anemia <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Cancer <input type="radio"/> COPD <input type="radio"/> CVA / TIA/ Stroke <input type="radio"/> Diabetes <input type="radio"/> High Blood Pressure <input type="radio"/> Low Blood Pressure <input type="radio"/> Kidney Disease <input type="radio"/> Migraine Headaches Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Transmissible Diseases</p> <p>In the last 3 months, have you been in contact with any of the following:</p> <p><input type="radio"/> SARS <input type="radio"/> Mumps <input type="radio"/> Meningitis <input type="radio"/> Rubella <input type="radio"/> Anthrax <input type="radio"/> Shingles <input type="radio"/> Measles <input type="radio"/> Zika Virus <input type="radio"/> Any type of flu/Influenza <input type="radio"/> NONE OF THE ABOVE Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Previous Cardiac Testing</p> <p><input type="radio"/> Echocardiogram Date: _____ <input type="radio"/> Treadmill Stress Test Date: _____ <input type="radio"/> Nuclear Stress Test Date: _____ <input type="radio"/> 24 Hour Holter Monitor Date: _____ <input type="radio"/> 30 Day Event Monitor Date: _____ <input type="radio"/> Carotid Ultrasound Date: _____ <input type="radio"/> Venous Ultrasound Date: _____</p>
<p><input type="radio"/> Alcohol Y/ N <input type="radio"/> Tobacco Past / Present / Never <input type="radio"/> Caffeine/Coffee/ Tea/ Soda</p>	<p>Family History If Living; Good/Fair/Poor Health & Present Age If Deceased; Cause of Death & Age</p>	
<p>Father</p>	<p>1. _____</p>	
<p>Mother</p>	<p>2. _____</p>	
<p>Brothers/ Sisters</p>	<p>3. _____</p>	
<p>Children</p>	<p>4. _____</p>	



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

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)

Menifee Valley Medical Center
Hemet Valley Medical Center

Alternative

Loma Linda Medical Center Murrieta
Rancho Springs Medical Center
Temecula Valley Hospital
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: _____



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Requesting Records From:

(Please provide name of physician, complete address and phone number)

Send Records To:

Sun City Cardiology Medical Center, Inc.

Bhoodev Tiwari, M.D., F.A.C.C.

Sun City Fax: 951-672-3758

Samir Artoul, MD, F.A.C.C.

Murrieta Fax: 951-246-9300

Information to be released is:

- | | | |
|--|---|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Angio/PTCA/Stent/Bypass |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Psychiatric/Drug Abuse | <input type="checkbox"/> Nuclear Tests |
| <input type="checkbox"/> X-Ray Report | <input type="checkbox"/> Billing Summary | <input type="checkbox"/> Holter |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Treadmill Stress Test | <input type="checkbox"/> Other: _____ |

Records Released are authorized for the following purpose:

- | | | |
|---|--|---|
| <input type="checkbox"/> Continued Care | <input type="checkbox"/> Personal Care | <input type="checkbox"/> Attorney/Legal |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> 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: _____

Signature of Patient _____ Date: _____

|| Bhoodev Tiwari, MD, FACC || || Samir Artoul, MD, FACC || Ali Dabestani, MD, FACC ||

WWW.SCCMC.COM



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

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:

Contacts We Are Allowed To Discuss Information With:

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

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:

THIS CONSENT FORM IS INDEFINITE UNLESS OTHERWISE SPECIFIED

Patient Name (printed): _____

Patient Signature: _____ Date: _____



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

INSURANCE ELIGIBILITY GUARANTEE FORM

I, _____, hereby certify that I am eligible for a health insurance policy.

I have chosen Dr. Bhoodev Tiwari and Dr. Artoul to be my cardiology care physician.

I request that payment of authorized insurance benefits be made on behalf of Dr. Bhoodev Tiwari 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

|| Bhoodev Tiwari, MD, FACC || || Samir Artoul, MD, FACC || Ali Dabestani, MD, FACC ||

WWW.SCCMC.COM



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

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



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

Cancellation & No-Show Policy

Our goal is to provide quality care in a timely manner. We schedule appointments in order to provide each patient with the individual attention that you deserve. We urge you to keep your scheduled appointments whenever possible.

Cancellation of an Appointment

In the event you need to cancel your appointment, please contact our office by phone and provide at least 24 hour notice. Your early cancellation allows us to offer your appointment to another patient requiring medical attention.

No Show Policy

A “no-show” is someone who misses their appointment without cancelling in advance or someone who arrives more than 15 minutes late to their appointment. If you arrive more than 15 minutes late to your scheduled appointment, we have the right to “No-Show” that appointment. Patients who No-Show 3 or more times in a 12 month period may be dismissed from the practice.

No Show & Cancellation Fee Policy Acknowledgement

By signing below, I acknowledge that I have reviewed the Cancellation & No-Show Policy. I agree to pay Sun City Cardiology Medical Center, Inc. a fee of \$25 in the event I am unable to make an appointment and do not notify the clinic in advance, do not cancel a scheduled appointment 24 hours in advance or show up to an appointment more than 15 minutes late without calling ahead of time.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

Office Staff Signature: _____ Date: _____



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

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.

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.
- 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.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

Office Staff Signature: _____ Date: _____

|| Bhoodev Tiwari, MD, FACC || || Samir Artoul, MD, FACC || Ali Dabestani, MD, FACC ||

WWW.SCCMC.COM



SC CARDIOLOGY MEDICAL CENTER, INC.

• Bhoodev Tiwari, M.D., FACC • Samir Artoul, M.D., FACC • Ali Dabestani, M.D., F.A.C.C.

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

Murrieta Office – 28078 Baxter Rd. Ste. 428, Murrieta, CA 92563 – P: 951-246-8881 – F: 951-246-9300

Bhoodev Tiwari, M.D., F.A.C.C.

Samir Artoul, M.D., F.A.C.C.

Ali Dabestani, M.C., F.A.C.C.

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

Date

Accepted

Denied

|| Bhoodev Tiwari, MD, FACC || || Samir Artoul, MD, FACC || Ali Dabestani, MD, FACC ||

WWW.SCCMC.COM