Coastal Healthcare

Dear: _____

We would like to thank you for choosing our office for your Cardiology and Nephrology needs. This letter will confirm your appointment scheduled for _____, 20__ at _____am-pm. You must arrive 30 minutes before your appointment to allow for entry of your information in to our electronic medical record system. If you are unable to keep this appointment, please call us as soon as possible to reschedule to a more convenient time for you. Prior to this appointment, please do the following:

1. Fill out the enclosed Patient Information, New Patient Questionnaire, Review of Systems, HIPPA Agreement, Billing Authorization, etc... Please date all forms with the date of your appointment.

2. If you have had a prior consultation with your primary doctor or another Cardiologist/Nephrologist in regard to your medical problem, please obtain your medical records to include any CT Scans, X-rays, Ultrasounds, recent labs, last office note and bring them with you to your appointment.

3. If your insurance company requires a referral/authorization, please be sure that you or your primary care physician have contacted your insurance to arrange for the appropriate referral prior to your scheduled appointment.

We look forward to seeing you. If you have any questions, please feel free to call our office or visit our website at www.mycoastalhealthcare.com.

Thank You

65 Nielson Street Suite 102 Watsonville, CA 95076 Tel: 831-768-6217 Fax :831-768-6219

Coastal Healthcare

Today's Date_____

Patient Information

Patient's Name: _____ Date of Birth: _____ Age: _____ Legal Gender: ____

Sexual Orientation: [ ]Homosexual [ ]Heterosexual [ ]Bisexual [ ]Other _____ [ ]Choose not to disclose

Gender Identity: [ ] Identifies with Male [ ] Identifies with Female [ ] Transgender FTM [ ] Transgender MTF [ ] Other

Assigned Sex at Birth: [ ]Male [ ]Female [ ]Choose not to disclose Circle Preferred Pronouns: He/Him She/Her They/Them

Address: _____ City, State, Zip: _____

Social Security # _____ Married____ Single____ Widowed____ Other_____

Home Phone #: _____ Cell Phone #: _____

Primary Physician _____ Referring Physician_____

Preferred Pharmacy _____ Preferred Lab _____Preferred Imaging Facility _____
Consent for Text Message Appointment Reminders: [ ]Yes [ ]No
Portal Access: [ ]Yes [ ]No Email Address: _____@_____

Responsible Party: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Address: _____ City, State, Zip: _____

Emergency Contact Name and Phone #: _____

Please complete this section even if we have a copy of your card!!

Primary Insurance: _____ Group #:_____

Subscriber's Name: _____ Date of Birth: _____

Social Security #: _____Subscriber ID#_____ Relationship to Patient: _____

Employer and Phone #: _____

Secondary Insurance: _____ Group #:_____

Subscriber's Name: _____ Date of Birth: _____

Social Security #: _____Subscriber ID#_____ Relationship to Patient: _____

Employer and Phone #: _____

Patient/Guardian Signature _____ Date Verified/Initials _____ _____ _____

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE

Coastal Health Partners

1. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:

I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, etcetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Facility to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice included in the Notice of Privacy Practices.

3. NOTICE OF PRIVACY PRACTICES:

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. GENERAL CONSENT FOR TESTS, TREATMENT. AND SERVICES:

I agree and understand that all physicians (including fellows, residents, physician assistants, nurse practitioners, and interns) involved in my care in any way are responsible and liable for their own acts and omissions, and the facility/practice is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the Facility. I understand that one or more physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

5. CONSENT TO PHOTO/VIDEO : (i.e.: X-Rays, Mammography, US, Surgeries, etc..)

_____ Please initial for consent to the photographing or videotaping, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained released in accordance with protected health information regulations.

6. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

____Yes ____ No I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

7. EMAIL:

_____Yes _____No I, hereby consent to provide my e-mail address, so that representatives from the Facility can e-mail information to me about health education or disease prevention and up-to-date information about the Facility, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

8. IMAGING SERVICES:

_____ Please initial to allow the facility's Imaging Services to share your images with affiliated facilities, when requested, for continuing medical treatment.

9. CELL PHONES:

____Yes _____No I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Facility, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

10. OPEN PAYMETNTS DATABASE:

The Open Payment database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I, _____ hereby grant Coastal Healthcare and their affiliates the authority to discuss my medical care; with the following people:

1. _____
2. _____
3. _____

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.			
Patient's Signature or Legal Representative		Date	Time
Relationship to Patient	Interpreter, if Utilized	Date	Time
Witness Signature I Date [Time	If Telephone Consent, Second Witness Signature	Date	Time

Coastal Healthcare

Dear Patient,

The US Department of Health and Human Services and the U.S. Centers for Disease Control and Prevention (CDC), working with several Accrediting organizations – Joint Commission, the National Committee for Quality Assurance and URAC – have set standards requiring the collection of race, ethnicity, and language data in order to track health care disparities and help promote equity.

Details about this requirement can be found on www.hhs.gov or www.ahrq.gov.

While it is mandatory that we ask these questions, you may decline to answer.

Please Complete and return to the Receptionist BEFORE you see the Provider.
Please check here if you decline to answer these questions. _____

Demographic information (please circle appropriate response)

Race: American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander Caucasian Other (Please specify) _____

Ethnicity: Hispanic Latino Not Hispanic or Latino

Primary Language: English ____ Spanish _____ Other (please specify) _____

Interpreter Services Needed: _____ YES _____ NO

Name _____DOB_____