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Patient Intake Form

___ Dr. Jorge Castellanos ___ Dr. Vinod Kannarkat

Last Name: _____ First Name: _____

Address: _____

City/State: _____ Zip Code: _____

Primary Phone #: _____ Secondary Phone #: _____

Date of Birth: _____ Social Security #: _____ Sex: Male / Female

Marital Status: Single Married Divorced Widowed Separated Domestic Partnership

Email Address: _____

Preferred Pharamacy**:**_____

Employment: Employed Retired Disabled Not Employed Self Employed
Employer: _____ Phone #: _____ Ext: _____

Spouse/Guardian Information:
Name: _____ Date of Birth: _____
Social Security #: _____ Phone #: _____

Insurance Information:
Primary Insurance: _____ Secondary Insurance: _____
Policy Holder: _____ Relationship: _____
Referred by: _____ Primary Care Physician: _____

Payment Information:
Credit Card Number: _____ Expiration Date: _____
Security Code: _____ Name on Card: _____
Emergency Contact: (someone not living with you)
Name: _____ Relationship: _____
Phone #: _____

I hereby give authorization for payment of my insurance benefits to be made directly to JMC Medical for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I agree to pay for all the cost of collection and reasonable attorney fees. I hereby authorize the release of all information necessary to secure the payment benefits.

Signature:_____ Date:_____

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MEDICAL HISTORY:

Do you have a history of:

High blood pressure?	Yes	No	Diabetes?	Yes	No
Coronary artery disease?	Yes	No	High cholesterol?	Yes	No
Pacemaker or ICD?	Yes	No	Heart failure?	Yes	No

Stroke? Yes _____ No
Date of event

Other conditions? _____

SURGICAL HISTORY:

Do you have a history of:

Heart surgery Yes _____ _____ No
Type of Surgery **Date of Surgery**

Other surgeries: _____ _____

_____ _____

_____ _____

_____ _____
Type of Surgery **Date of Surgery**

FAMILY HISTORY

Is there anyone in your family who was diagnosed with:

Heart disease at the age of 55 or younger? Yes _____ No

Bicuspid or unicuspid aoritic valve? Yes _____ No

Dilated aorta or aortic aneurysm? Yes _____ No
Family Member

Other conditions? _____ _____

_____ _____

_____ _____
Medical Condition **Family Member**

Is there anyone in your family who underwent open heart surgery younger than 55?

Yes _____ No
Family Member

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MEDICATIONS (include supplements and nonprescription medications)

Name	Dose (mg, etc)	How often?

Do you have any known drug allergies? Yes _____ No

SOCIAL HISTORY

Birthplace: _____

Do you drink alcohol?_____ If yes, how much per day?_____

Tobacco: Never Smoked Quit-when? _____ Current Smoker? Packs/day___

Have you used drugs other than those for medical reasons in the past 12 months?

No Yes _____

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Authorization to Obtain or Release Medical Records from Medical Providers

I hereby authorize JMC Medical to obtain any and all medical records concerning my care from any physician, hospital or other healthcare professional that has provided medical care to me in the past.

I also authorize JMC Medical to release any and all medical records concerning my care to any physician; hospital or other healthcare professional providing care to me at any time. Additionally, I authorize JMC Medical to release any and all medical records concerning my care to medicare, Medi-Cal, any insurance company, third party administrator, or managed care company. This release does not have an expiration date.

Patient Name_____ Date of Birth_____

Patient Signature_____ Date _____

Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implanted through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff at JMC Medical to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.
*****In the event of a critical episode or if you are unable to give authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize JMC Medical to release any or all information concerning my medical care to any individual except as set forth above (*)

_____ I authorize JMC Medical to release any or all information concerning my medical care to the following individuals:

Name_____ Relationship_____

Name_____ Relationship_____

Patient Signature_____ Date _____

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and Disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications if that communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I wish to be contacted in the following manner:

- ☐ Home Telephone:_____
  - ☐ Okay to leave a message with detailed information
  - ☐ Leave a message with call back number only
- ☐ Work Telephone:_____
  - ☐ Okay to leave a message with detailed information
  - ☐ Leave a message with call back number only
- ☐ Cell Phone:_____
  - ☐ Okay to leave a message with detailed information
  - ☐ Leave a message with call back number only
- ☐ Written Communication:
  - ☐ Okay to mail to my home address
  - ☐ Okay to mail to my work
  - ☐ Okay to fax to this number:_____
  - ☐ Okay to send an email:
- ☐ Other:_____

Test Results Policy

Unlike other medical offices, when one of our patients has any type of laboratory test, x-ray or cardiology results pending, it is our office policy to request that the patient call our office for these results. Do not assume that they are normal if you have not heard from us. We feel that you should know and if desired, have copies of all tests performed, but that you should take responsibility to make sure you know they have been reviewed. If abnormal tests results are found, we plan to inform you, however, at times, the results are sent to the wrong physician or to your primary care physician and not to our offices. Please sign below so our office is advised that you have been informed and understand it fully.

Signature:_____ Date:_____

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Appointment Policy

JMC Medical requires a 24-hour cancellation notice for all appointments. There is a $50 charge for any appointment that is not canceled within this period. JMC Medical is **open by appointment only** and cannot accommodate walk-in patients. Patients who arrive on time are seen at their appointment time. If you arrive late, we may need to abbreviate or reschedule your visit. Call ahead if you are running late or unable to make your appointment time. We will do all that we can to accommodate your appointment and minimize the need to reschedule your appointment.

Financial Policy

We are committed to providing you the best of cardiac care. Copayment and deductible payments are determined by your agreement with your insurance carrier. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for payment. Payment is due upon receipt of an invoice from our office. We accept checks and all major credit cards. Cash is NOT accepted.

Regarding Insurance Billing: We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to the contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and or the guarantor listed on the patient information form.

HMO plans: (with which we are contracted): All co-pays must be satisfied at every visit. There can be no exception. Due to the contractual and uniform compliance issues with your insurance company, you are responsible for obtaining prior approval with your medical group or PCP prior to treatment.

PPO plans: (with which we are contracted) Your coinsurance is your responsibility and is due at the time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of pocket deductible or coinsurance amounts.

Medicare: We accept assignments with medicare. Medicare pays 80% of their allowed amount after you satisfy the yearly deductible. You are responsible for 20% of Medicare’s allowed amount. We will bill your secondary insurance as a courtesy.

Usual and customary rates: Our practice is committed to providing the best treatment for your patients and we charge what is usual and customary for our area. You are responsible for payment, regardless of any insurance company’s arbitrary determination of usual customary rates.

Cash patients: All services must be paid in full at the time of treatment, unless prior arrangements have been made. There is a 20% discount applied if services are paid in full at the time of treatment.

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JMC Medical Records Charges

Our office policy regarding medical records, forms, letters and clearance notes is as follows:

- There is a $25 charge for anything listed below
    - Any form needing to be filled out and signed by your provider
    - Any doctor's note or letter
    - Preoperative risk assessment forms
    - Records released from our office
        - Flat rate of $25 or 0.25 per page
- $50 charge for copy of echocardiogram images on CD
- There is no charge to send records to your referring physicians
- There will be a $15 charge to send records if you are changing physicians

Please be advised records, forms and letters will not be released until payment has been received. If you have any questions, please contact the office at (949) 881-7883.

Notice of Privacy Practice, Financial Policy and JMC Medical Records Signatures

Thank you for understanding the privacy practice, financial policy and JMC Medical records charges. Please let us know if you have questions or concerns. You can reach the office manager at (949) 881-7883.

I have received a copy of the Notice of Privacy Practices, Financial Policy for JMC Medical and JMC Medical records charges.

Patient Name_____ Date of Birth_____

Patient Signature_____Date_____