Pacific Coast Heart Center

Christine M. Theard M.D
(949)495-0800 Office,
(949)495-0805 Fax

33971 Selva Road Ste. 250
Dana Point, CA 92629
PacificCoastHeartCenter.com

Dear patient:

These are new patient forms. Please mail, fax (949 495-0805) or e-mail (pchc@att.net) your completed forms to the office before your appointment. We request that you send them to us prior to your appointment. If you are not able to do so, please arrive fifteen minutes before your scheduled time in order to complete the documents.

YOUR APPOINTMENT IS SCHEDULED FOR

_____

IMPORTANT INSURANCE INFORMATION

Pacific Coast Heart Center is a PPO (Participation Provider Organization) and Covered CA only provider.

HMO (Heath Maintenance Organization) policy plans will not be accepted. If you have chosen to see Dr. Theard with this type of insurance plan you will be required to pay for the procedures performed at the time of service (Self pay).

Note that the patient is responsible for unpaid or denied claims. Please be prepared to pay your copayment, coinsurance, and/or deductible at the time of service.

We welcome you and look forward to providing you care.

Sincerely,

Christine M. Theard, M.D.
And Staff

Enclosure

Pacific Coast Heart Center

Christine M. Theard, M.D. 33971 Selva Road, Suite 250, Dana Point, CA 92629
www.PacificCoastHeartCenter.com Ph: (949) 495-0800
pchc@att.net Fax: (949) 495-0805

Name:_____ Referred by:_____

Date of Birth: _____/_____/_____ SSN: _____/_____/_____ Age:_____

Mailing Address:_____

City:_____ State: _____ Zip: _____

Home #:_____ Business #:_____ Cell #:_____

Email:_____.

Marital Status (check one): Single: _____ Married: _____ Partnered: _____ Divorced: _____ Widowed: _____

Emergency Contact Name: _____ Phone:_____ Relation: _____

Employer Name (if insured through): _____

Address:_____ City:_____ State:_____ Zip:_____

Primary Care Physician:_____ Phone: _____ Fax:_____
(Required)

Primary Insurance Company:_____

Policy Holder Name (if different from above): _____ Relation: _____ DOB:_____

Secondary Insurance Company:_____

Policy Holder Name (if different from above): _____ Relation: _____ DOB:_____

Benefit Assignment:
I directly assign all medical and surgical benefits to Pacific Coast Heart Center. I understand that I am responsible for any charges of services as well as any deductible, co-payment, or charges required by my insurance company. Failure to provide accurate or current insurance information will result in all charges to become the full responsibility of the patient. I authorize Pacific Coast Heart Center to release information as indicated for payment of benefits.

Patient Signature: _____ Date: _____

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose individually identifiable health information except as provided for in our Notice of Privacy without patient authorization. Completion of this form means patient is giving permission for the disclosure as described below:

I, (Name, Address) _____
hereby authorize Pacific Coast Heart Center to use and disclose any and all health information to any referral physician and to health care plans for billing purposes.

Patient Signature: _____ Date: _____

If not signed by patient, please indicate your relationship to patient _____

A copy of HIPPA is available upon request. Patient may revoke this authorization at any time by notifying this practice in writing.

Insurance Eligibility Waiver

I_____ am eligible for _____ as of _____
(Full Name) (Insurance Plan) (Effective Date)

Through _____
(Self/Policy Holder/Employer)

I understand that it is my responsibility to know which physicians and services are covered under my insurance plan. Services rendered that are not covered become my responsibility. Pacific Coast Heart Center will bill the appropriate insurance company(ies) promptly and will expect payment. If payment is not received after 90 days charges will become the patient's responsibility. Insurance company or policy issues are up to the patient to resolve directly with the insurance company. Changes in insurance information, mailing address, and/or phone numbers are the responsibility of the patient to update with Pacific Coast Heart Center.

Patient Signature: _____ Date: _____

Appointment Agreement

Pacific Coast Heart Center maintains a high standard by providing prompt and urgent cardiology care for new and existing patients. Therefore, it is necessary that we request your respect and consideration in regard to our schedule. Please provide the office with a 48 hour advance notification if you are unable to keep our scheduled appointment for an initial evaluation and a 24 hour advance notification for any follow-up evaluations.

If you notify us of your cancellation, we have the opportunity to fill that time with other patients. Failure to notify the office of a cancellation will result in a fee of $75.00 for "no show." Please note that this fee is not covered by insurance.

I understand that I am responsible for all fees pertaining to a visit if I fail to notify Pacific Coast Heart Center as noted above.

Patient Signature: _____ Date: _____

Welcome to the Pacific Coast Heart Center
33971 Selva Road, Ste 250
Dana Point, CA 92629

Name: _____ Age: _____

Referring Doctor: _____ Birthdate: ___/___/___

Medical History:

What is the main problem that you have today? _____

Do you have chest pain? Yes_____ No _____ If yes, please describe: _____

Do you have problems with your breathing? Yes _____ No _____ If yes, please describe: _____

Do you have palpitations? Yes _____ No _____ If yes, please describe: _____

Do you have swelling of your hands or feet? Yes _____ No _____ If yes, please describe: _____

Do you have a history of heart problems? Yes _____ No _____ If yes, please describe: _____

Do you have: High Blood Pressure? . . . . . Yes _____ No _____ If yes, how long? _____
Diabetes? . . . . . Yes _____ No _____ If yes, how long? _____
High Cholesterol? . . . . . Yes _____ No _____ If yes, how long? _____
Family History of Heart Attacks or Strokes? Yes _____ No _____ If yes, who had these problems? _____

Do you smoke now? Yes _____ No _____ If yes, what is the most you smoke daily? _____ packs per day.
Did you ever smoke? Yes _____ No _____ If yes, what is the most you smoked daily? _____ packs per day.
When did you stop smoking? _____

Please list any other medical problems: _____

Please list any surgical procedures: _____

Family History:

Mother: Alive at age _____ or deceased at age _____ Medical problems: _____
Father: Alive at age _____ or deceased at age _____ Medical problems: _____
Brothers: Alive at age _____ or deceased at age _____ Medical problems: _____
Alive at age _____ or deceased at age _____ Medical problems: _____
Sisters: Alive at age _____ or deceased at age _____ Medical problems: _____
Alive at age _____ or deceased at age _____ Medical problems: _____

Grandparents:
Maternal grandmother: Alive at age _____ or deceased at age _____ Medical problems: _____
Maternal grandfather: Alive at age _____ or deceased at age _____ Medical problems: _____
Paternal grandmother: Alive at age _____ or deceased at age _____ Medical problems: _____
Paternal grandfather: Alive at age _____ or deceased at age _____ Medical problems: _____

Please list your allergies:
Medication: _____ Type of reaction you experienced: _____
Medication: _____ Type of reaction you experienced: _____
Medication: _____ Type of reaction you experienced: _____

Please list your present medicines. Use back of this sheet if more room is needed: _____

*Office Use: Patient Last, First Name*_____

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Guarantee of Payment (GOP) – Credit Card Authorization Form

Pacific Coast Heart Center has chosen to accept your PPO insurance plan for payment of your services. Your insurance plan determines how much we are allowed to charge for our services. They also determine the amount you are expected to pay based on the terms and conditions of your policy and deductible.

We would appreciate your payment of this amount at the time of your visit. If you cannot pay at the time of service we require you to provide a valid credit/debit card, which will be filed and charged after we receive a response from your insurance company.

Patient Name: _____ Patient DOB: _____

Name (as it appears on card): _____

Card #: _____

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Expiration: ___ / ___ (mm/yy) Security Code: _____ Your Billing Zip Code : _____

I certify that I am the authorized holder and signer of the credit card referenced above and that all information is complete and accurate.

I hereby authorize collection of payment for all charges as explained above. My signature indicates that I have read and agree with the Guarantee of Payment policy. I understand that I will be charged for the portion that is my responsibility.

_____ _____

Cardholder Signature Date

Would you like a receipt of charges made: ☐ Yes ☐ No

Mail _____

-Or- (Address) (City, State, Zip)

Email _____

-Or-

(Print Clearly)

Fax _____

Note: If you would like to request a payment plan for charges exceeding a specific amount please inform the receptionist. The Billing Manager will contact you to arrange and discuss payment options.