

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 (Health 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.
www.PacificCoastHeartCenter.com
pchc@att.net

33971 Selva Road, Suite 250, Dana Point, CA 92629
Ph: (949) 495-0800
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: _____

Physician Open Payments Notice

The Open Payments 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>

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public

I acknowledge that I have been provided the above reference information.

Patient Signature: _____ Date: _____

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

