Atul Aggarwal MD
CARDIOLOGY CLINIC

Contact/Insurance Info

MRN: _____

email: _____

Patient Name: _____
Last First MI

Date of Birth: _____ **Male** **Female**

Social Security No. _____–_____–_____ **Marital Status:** Single Married Widowed Divorced

Address: _____
Street City Zip

Home Phone No. (_____) _____–_____ **Cell Phone/Work Phone No.** (_____) _____–_____

Emergency Message Phone: (_____) _____–_____

Emergency Contact: _____ **Relationship:** _____

Name of Spouse: _____ **Phone:** (_____) _____–_____

Address (If different than above)**:** _____
Street City Zip

ResponsibleParty: _____

Address: _____

Employer Name: _____

Address: _____

Primary Insurance Carrier: _____

Subscriber Identification #: _____

Subscriber Name: _____

Referred By: _____

Primary Physician: _____

Atul Aggarwal MD Cardiology Clinic

HEALTH APPRAISAL QUESTIONNAIRE

Patient Name: _____ **MRN:** _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female **Weight:** _____ **Height:** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Referred by: _____

Primary Medical Doctor: _____

What is your chief complaint or referral: _____

_____

History of Present Illness: _____

_____

Have you or are you now experiencing any of the following?

	Yes	No		Yes	No
Pressure or pain in the chest, arms, neck?	☐	☐	Swelling of ankles, feet, or stomach?	☐	☐
Dizziness, lightheadedness, blackouts, or fainting	☐	☐	Pain, discomfort, or cramping in legs when walking?	☐	☐
Palpitations, fast, skipped, or irregular heartbeats?	☐	☐	Temporary loss or disturbance of speech?	☐	☐
Difficulty breathing?	☐	☐	Temporary weakness of one side of body?	☐	☐
With activity?	☐	☐	Other: _____		
When lying flat?	☐	☐			

Current/Past Medical History	Yes	No	
Current/Past Medical History	☐	☐	Month/Year _____
Coronary artery disease	☐	☐	Month/Year _____
Heart Attack	☐	☐	Month/Year _____
Cardiac catheterization/angiogram	☐	☐	Month/Year _____
Bypass Surgery	☐	☐	Month/Year _____
Angioplasty/stent	☐	☐	Month/Year _____
Defibrillator	☐	☐	Month/Year _____
Pacemaker	☐	☐	Month/Year _____
Congestive Heart Failure	☐	☐	Month/Year _____
Heart Murmur	☐	☐	Month/Year _____
Heart Valve Surgery	☐	☐	Month/Year _____
Stroke	☐	☐	Month/Year _____
Mini Stroke/TIA	☐	☐	Month/Year _____
Peripheral Ventricular Disease	☐	☐	Month/Year _____
Blood clots (lungs Legs)	☐	☐	Month/Year _____
Aneurysm	☐	☐	Month/Year _____
Hypertension	☐	☐	Month/Year _____
High Cholesterol	☐	☐	Month/Year _____
Diabetes	☐	☐	Month/Year _____
Cancer (specify _____)	☐	☐	Month/Year _____
Other	☐	☐	Month/Year _____

List all surgeries: _____

_____

Hospitalizations: _____

Atul Aggarwal MD Cardiology Clinic

HEALTH APPRAISAL QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Social History

Tobacco use: Current use: YES ☐ No ☐ If yes, amount: _____ /day How long? _____
If history of smoking in the past, when quit: _____

Alcohol use: Current use: YES ☐ No ☐ Ounces/week Liquor: _____ Wine: _____ Beer: _____

Street Drugs: Marijuana YES ☐ No ☐

Caffeine: Current use: YES ☐ No ☐ Type_____ Amount/day: _____

Family History:	Yes	No	Family Member:		Yes	No	Family Member:
Heart Disease	☐	☐	_____	High Blood Pressure	☐	☐	_____
Bypass Surgery	☐	☐	_____	Stroke	☐	☐	_____
Heart Attack (age under 60)	☐	☐	_____	Cancer	☐	☐	_____
High Cholesterol	☐	☐	_____	Diabetes	☐	☐	_____

Review of systems
Do you currently, or have you ever had any problems in the following areas?

General	Yes	No
Weight loss/gain	☐	☐
Tire easily, weakness	☐	☐
Head/Neck		
Headache	☐	☐
Migraine	☐	☐
Lumps in neck	☐	☐
Goiter	☐	☐
Blocked arteries in neck	☐	☐
Nuerologic		
Seizures disorder	☐	☐
Epilepsy	☐	☐
Numbness/weakness in arms/legs	☐	☐
Problems with speech	☐	☐
Eyes/Ears/Nose/Throat		
Glaucoma	☐	☐
Cataract	☐	☐
Blurred Vision	☐	☐
Double vision	☐	☐
Sinus congestion	☐	☐
Dry Mouth/throat	☐	☐
Hoarseness	☐	☐
Hearing Loss	☐	☐
Ringing in the ears	☐	☐
Vertigo	☐	☐
Allergies/Hay fever	☐	☐

Pulmonary	Yes	No
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Wheezing	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Wheezing	☐	☐
Chronic Cough	☐	☐
Valley Fever	☐	☐
Tuberculosis	☐	☐
Gastrointestinal		
Poor Appetite	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Indigestion	☐	☐
Heartburn	☐	☐
Colitis	☐	☐
Diverticulitis	☐	☐
Ulcers	☐	☐
Intestinal Bleeding	☐	☐
Hiatal Hernia	☐	☐
Liver Disease	☐	☐
Hepatitis	☐	☐
Difficulty Swallowing	☐	☐
Endocrine		
Thyroid Problems	☐	☐
Diabetes	☐	☐

Atul Aggarwal MD Cardiology Clinic

HEALTH APPRAISAL QUESTIONNAIRE

Genitourinary	Yes	No
Blood in urine	☐	☐
Pain during Urine	☐	☐
Incontinence	☐	☐
Difficulty in urination	☐	☐

Musculoskeletal		
Back pain	☐	☐
Joint Pain	☐	☐
Difficulty walking	☐	☐

Skin	Yes	No
Rash	☐	☐
Easy bruising	☐	☐
Scaling	☐	☐

Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Suicidal thoughts	☐	☐

Medication History

Have you been vaccinated for influenza? ☐ Yes ☐ No

Have you been vaccinated for pneumonia? ☐ Yes ☐ No

Do you have any drug allergies? ☐ Yes ☐ No Name of meds that you are allergic to _____

Are you allergic to:

- Iodine: ☐ Yes ☐ No
- Aspirin: ☐ Yes ☐ No
- Seafood: ☐ Yes ☐ No
- Penicillin: ☐ Yes ☐ No

Medications take at home:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Atul Aggarwal MD
CARDIOLOGY CLINIC

AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I hereby authorize_____

Name of Physician, Hospital, or Health Care Provider

to disclose to Atul Aggarwal MD cardiology Clinic, 1018 Calloway Drive, Bakersfield CA 93312, Tel no. 6616640100, Fax no. 66166640111 my medical records and information pertaining to medical history, physical condition, services rendered, or treatment of

Patient Name: _____

Last First MI

Date of Birth: _____ **Social Security No.** _____–_____–_____

Address: _____

Street City Zip

Phone No. (_____) _____–_____

The purpose of this release is:

- ☐ to disclose the protected health information at my request
- ☐ other: _____

I authorize the below information to be disclosed on my behalf:

- ☐ Clinic Notes
- ☐ Discharge summary
- ☐ Stress test report
- ☐ Echo report
- ☐ Catheterization report
- ☐ OEKG

☐ Any and all records for _____

From _____ To _____

Atul Aggarwal MD
CARDIOLOGY CLINIC

Authorization shall remain in effect for one (1) year from date of signature.

I understand that I may revoke this authorization at any time by sending a written request to:

Atul Aggarwall MD Cardiology Clinic
1018 Calloway Drive
Bakersfield CA 93312

The fact that I revoke this authorization will not affect actions taken while the authorization is voluntary and that Atul Aggarwal MD Cardiology Clinic will not sign this authorization. I understand that Information disclosed pursuant to this be considered protected health information. I am entitled to a copy of this authorization.

_____ _____

Signature of Member *Date*

Guardians and legal Representatives: If signing as a guardian or legal representative on behalf of the member, the following information must be completed. If signing as a legal representative, a copy of a health care power of attorney, a court order, or other legal documentation demonstrating your authority as legal representative to act on the member's behalf must be attached.

Full Name of legal representative: _____

Legal relationship to member: _____

_____ _____

Signature of Representative *Date*

Atul Aggarwal MD
CARDIOLOGY CLINIC

Assignment of Benefits

I hereby assign to Atul Aggarwal MD Cardiology Clinic all medical and/or surgical benefits to which Atul Aggarwal MD Cardiology Clinic is due for my bill. By signing below, I am consenting that payments from authorized Medicare, Medicaid, Government and any other insurance or third-party benefits can be made on my behalf, and/or on behalf of all members covered under my insurance plan, directly to Atul Aggarwal MD Cardiology Clinic for services provided. This assignment will remain in effect until revoked by myself. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree to pay all the costs of collection, including, but not limited to, reasonable attorneys' I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

Date: _____ Patient Signature: _____

Insured's Signature: _____

Medicare Assignment

If you have Medicare, please sign the following:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Atul Aggarwal MD Cardiology Clinic for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these 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 coverage is indicated in item 9 of the CMS-1500 claim form or elsewhere on their approved claim forms or electronically submitted claims, 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, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____ Date: _____

If signature is other than patient's signature, write in patient's name followed by the signature of person signed, and compete the following:

Name of signing party: _____

Address of signing party: _____

Relationship of patient: _____

Reason patient could not sign: _____

Content to release information

I hereby authorize Atul Aggarwal MD Cardiology Clinic to furnish information to any referring physician, agency or insurance company(s) I have listed on the Patient Information Form.

Patient Signature: _____ Date: _____

For a copy of this financial policy document, please request a copy from our receptionist.

Dr Atul Aggarwal, MD, FACC, FAHA, FSCAI, *Interventional Cardiologist*
1018 Calloway Dr ive • Bakersfield CA 93312
www.aggarwalclinic.com

Atul Aggarwal MD
CARDIOLOGY CLINIC

NOTICE ABOUT OPEN PAYMENTS DATABASE

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 openpaymentsdata.cms.gov.

_____ _____

Patient Signature *Date*

_____ _____

Signature of Representative *Date*

Dr Atul Aggarwal, MD, FACC, FAHA, FSCAI, *Interventional Cardiologist*
1018 Calloway Dr ive • Bakersfield CA 93312
www.aggarwalclinic.com

RELEASE OF INFORMATION TO SPECIFIC INDIVIDUALS

Patient Name: _____ **Date of Birth:** _____

☐ I authorize Atual Aggarwal MD Cardiology Clinic to release

☐ All information

OR

☐ Limited information, as further described:

To the following individuals:

1. _____
Name *Relationship*

2. _____
Name *Relationship*

3. _____
Name *Relationship*

Message Delivery of information

☐ I authorize Atul Aggarwal MD Cardiology Clinic, its physicians and employees to leave messages regarding:

☐ Any information (including test results)

OR

☐ Limited information, as further described: _____

_____

At the following phone number(s) listed below.

Home: ☐ YES ☐ NO Number: _____

Cellular: ☐ YES ☐ NO Number: _____

Work: ☐ YES ☐ NO Number: _____

The purpose of this release is to disclose the protected health information at my request. I understand that this authorization will remain in effect for one year from the date of signature. I also understand that I may revoke this authorization for Release of Medical Information at any time by sending a written request to:

Atul Aggarwall MD Cardiology Clinic
1018 Calloway Drive
Bakersfield CA 93312

The face that I revoke this authorization will not affect actions take while the authorization was in effect, before the revocation is received. I understand that this authorization is voluntary and that Atul Aggarwal MD cardiology Clinic will not condition treatment, payment, enrollment, or eligibility for benefits upon whether I sign this authorization. I understand that information disclosed pursuant to this authorization could be subjected to re-disclosure by the recipient and might no longer be considered protected health information. I am entitled to a copy of this authorization.

_____ _____

Signature of Member *Date*

Guardians and Legal Representatives: If singing as a guardian or legal representative on behalf of the member, the following information must be completed. If signing as a legal representative, a copy of a health care power attorney, a court order, or other legal documentation demonstrating your authority as a legal representative to act on the member's behalf must be attached.

Full Name of legal representative: _____

Legal relationship to member: _____

_____ _____

Signature of Representative *Date*

Atul Aggarwal MD
CARDIOLOGY CLINIC

HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgment of Written Consent/Authorization

I hereby give consent/authorization to Atul Aggarwal MD Cardiology Clinic to use or disclose, either verbally or in-writing, my protected health information for the purposes described in this Notice of Privacy Practices.

I further acknowledge that the Atul Aggarwal MD Cardiology Clinic has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my PHI.

_____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Print name of Patient | Patient Date of Birth

_____

Print Name of Parent of Legal Guardian

Dr Atul Aggarwal, MD, FACC, FAHA, FSCAI, *Interventional Cardiologist*
1018 Calloway Dr ive • Bakersfield CA 93312
www.aggarwalclinic.com

Atul Aggarwal MD
CARDIOLOGY CLINIC

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Atul Aggarwal MD Cardiology Clinic (the "Clinic") and your legal rights regarding your protected health information held by the Clinic under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This notice of privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "**P**rotected **H**ealth **I**nformation" ("**PHI**") is individually identifiable health information, including demographic information, collected from you or created by a health care provider, that relates to (1) your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

Our Responsibilities. We are required by law to:

- Maintain the privacy of your **PHI**;
- Provide you with certain rights with respect to your **PHI**;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your **PHI**; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your **PHI** that we maintain, as allowed or required by law.

Uses and Disclosures of Protected Health Information: Your **PHI** may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, billing for services provided,, to supporting the operation of the physician's practice, and any other use required by law.

For Treatment: We may use or disclose your **PHI** to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. *For example, the clinic might disclose information about you to a another physician who is treating you.*

For Payment: We may use or disclose your **PHI** to facilitate payment for the treatment and services you receive. *For example, the Clinic may tell your health insurance plan about treatment to obtain approval or to determine whether your plan will pay for the treatment.*

For Health Care Operations: We may use and disclose your **PHI** for other health care operations. These uses and disclosures are necessary to run the Clinic. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. *For example, the Clinic may use and disclose your protected health information to medical students involved in direct patient care in our office. In addition, we may use a sign-in sheet at the registration desk to obtain your name and physician. We may also call you by name in the waiting room when you are being escorted to the back office.*

To Business Associates: We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use, or disclose your **PHI**, but only after they agree in writing with use to implement appropriate safeguards regarding your **PHI**.

Disclosures to you: When you request, we are required to disclose to you certain portions of your **PHI**. We are also required, when requested, to provide you with an accounting of most disclosures of your **PHI** where the disclose was for reasons other than for payment, treatment or health care operations, and where the protected**PHI** not disclosed pursuant to your individual authorization.

For Appointment Reminders and Other Health information: The Clinic may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Special situations: We may use or disclose your **PHI** in certain situations when required by state or federal law without your authorization. These situations include:

> As required by Law: Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Medical Examiners; Funeral Directors; Organ Donation; Research; Criminal activity, Military Activity; National Security; Worker's Compensation; Inmates - required Uses and Disclosures; Government Audits.

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR Subpart E.

Personal Representatives: We will disclose your **PHI** to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the Privacy Rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. You have been, or may be, subjected to domestic violence, abuse or neglect by such person;
2. Treating such person as your personal representative could endanger you; or
3. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Authorizations: Other uses or disclosures of your **PHI** not described above will only be made with your written authorization. Uses and disclosures of **PHI** for marketing purposes, and disclosures that constitute a sale of **PHI** require authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon written authorization and prior to receiving your written revocation.

Your rights: The Following is a statement of your rights with respect to your **PHI**:

You have the Right to inspect and Copy your PHI: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of or use in, a civil, criminal or administrative action or proceeding, and **PHI** that is subject to law that prohibits access to protect health information.

Atul Aggarwal MD
CARDIOLOGY CLINIC

You have the Right to Request a Restriction: You have the right to request a restriction or limitation on your **PHI**. This means you may ask us not to use or disclose any part of your **PHI** for the purposes of treatment, payment or healthcare operation. You may also request that any part of your **PHI** not be disclosed to family members or friends who may be involved in your care of for notification purposed as described in this Notice of Privacy Practices. You have the right to restrict certain disclosures of **PHI** to health plan where you pay out of pocket in full for the health care items or services we provide. Your request must state the specific restriction requested and to whom you want the restriction to apply. Except in limited circumstance, or where you pay out of pocket in full, we are not required to agree to a requested restriction.

You have the Right to Request Confidential Communications: You have the right to request in writing that we communicate with you about medical matters in certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

You have the Right To Obtain a Paper Copy for this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

You may have the Right to Amend your PHI: If you feel that the **PHI** we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request, in writing, an amendment for as long as the information is kept by or for the Plan. If we deny your request or amendment, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the Right to be Notified of a Breach: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured **PHI**.

You have the Right to an Accounting of Disclosures: You have the right to receive an accounting of certain disclosures we have made, if any of your **PHI**.

You have the Right to Opt Out of Fundraising Communications: If the Clinic were to decide to engage in fundraising, you would have the right to opt out of receiving these fundraising communications at the time of the solicitation.

Complaints: You may complain to use or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by Atul Aggarwal MD Cardiology Clinic. You may file a compliant with Atul Aggarwal MD Cardiology Clinic by notifying our office of your compliant. Retaliation against any patient of this practice for filing a complaint against this practice is strictly prohibited.

Questions: If you have any questions about this policy or need further information, please contact Sonali Aggarwal, the Clinic's Privacy Officer, at (661) 664-0100.

This notice was published and became effective on or before **April 14, 2003.**
Rev.(2): **February 1, 2023**

You may revoke any authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Atul Aggarwal MD
CARDIOLOGY CLINIC

APPOINTMENT CANCELLATION POLICY

Acknowledgment of Written Consent/Authorization

If an appointment for an ultrasound or treadmill stress test is missed, canceled or changed with less than 24 hours notice, there will be a $25 charge.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Dr. Atul Aggarwal, MD Cardiology Clinic as described above.

Thank you for your understanding and cooperation.

_____ _____

Firma del Paciente: Fecha

Dr Atul Aggarwal, MD, FACC, FAHA, FSCAI, *Interventional Cardiologist*
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