10601 Walker Street
Cypress, CA 90630

HeartScape
Cardiovascular Center
of Orange County

Phone: 714-656-2140
Fax: 714-252-8482

Rex Winters, M.D., Inc.

PATIENT INSURANCE INFORMATION

PLEASE PRINT UPDATE:

PATIENT INFORMATION

NAME: (LAST) (FIRST) (INITIAL)	SOCIAL SECURITY NO:	MARITAL STATUS: ❑ SIN ❑ MAR ❑ WID ❑ DIV ❑ SEP	SEX: ❑ MALE ❑ FEMALE
ADDRESS: (NO.) (STREET OR RR#) (CITY) (STATE) (ZIP)	HOME PHONE NO:	AGE:	DATE OF BIRTH:
PATIENT OR PARENT'S EMPLOYER: / OCCUPATION:	EMPLOYER'S ADDRESS:		BUSINESS PHONE NO:
SPOUSE NAME:	SPOUSE'S EMPLOYER:	OCCUPATION:	BUSINESS PHONE NO:
RESPONSIBLE PARTY: (IF DIFFERENT FROM PATIENT) (LAST) (FIRST) (INITIAL)		PATIENT RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER:	
RESPONSIBLE PARTY ADDRESS: (NO.) (STREET OR RR#) (CITY) (STATE) (ZIP)		HOME PHONE NO:	
EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:		PHONE NO:

PRIMARY INSURANCE COVERAGE

POLICY HOLDER'S NAME: (IF DIFFERENT FROM PATIENT)	EMPLOYER:
INSURANCE CO. NAME & ADDRESS:	
SUBSCRIBER'S SOCIAL SECURITY NO:	RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE COVERAGE

POLICY HOLDER'S NAME: (IF DIFFERENT FROM PATIENT)		EMPLOYER:
INSURANCE CO. NAME & ADDRESS:		
POLICY NO:	GROUP OR MEDICAID NO:	RELATIONSHIP TO PATIENT:

PLEASE NOTE: THE ABOVE FORM MUST BE COMPLETED IN ITS ENTIRETY. ANY INCOMPLETE SPACES MAY SLOW PATIENT PROCESSING.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE REX WINTERS, M.D., INC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT AND HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE: SIGNATURE:

REFERRING PHYSICIAN:

REFERRING PHYSICIAN ADDRESS:

METHOD OF PAYMENT:

❑ CASH ❑ CHECK ❑ CREDIT CARD

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PATIENT HISTORY & PHYSICAL FORM

We thank you in advance for taking the time to complete this information. This will assist your physician in providing the best care for you.

Name: _____ DOB: _____ Age: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Primary Care/Family Physician: _____

What is the reason for today's visit? Please list any problems that you are experiencing.

_____

_____

_____

Medications (Please list the name, dose & how often or attach a current printed list if you have one)

Name	Dose	How Often	Name	Dose	How Often

Pharmacy Name: _____ **Number:** _____

Allergies (Please list your allergies.)

_____ _____ _____

Are you allergic to X-ray dye? ____ Yes ____ No Please explain: _____

Risk Factors

1) Do you smoke? ____ Yes ____ No

- If yes, how many packs per day? _____ For how many years? _____
- If no, did you ever smoke regularly? ____ When did you stop? _____

What other tobacco products do you use besides cigarettes? _____

2) Do you have diabetes? _____ Yes _____ No

If so, for how long? _____ Do you take medications for your diabetes? _____

3) Have you ever been told that you have high blood pressure? Yes _____ No _____

4) Do you have a family member (father, mother, brother, sister) that has had a heart attack, a stent, heart bypass surgery or a stroke? If so, who and at what age? _____

_____

_____

_____

5) Have you ever been told that you have high cholesterol? Yes _____ No _____
If so, has your cholesterol ever required cholesterol medication? Yes _____ No _____
If so, please explain: _____

_____

"FOR FEMALES ONLY"

1.) At what age did you have your last menstrual period? _____
2.) Have you ever taken hormone replacement therapy (estrogen) ? _____ Yes _____ No
If so, when and what type? _____
3.) Have you had a hysterectomy? _____ Yes _____ No Explain: _____
4.) Are you pregnant or breastfeeding? _____ Yes _____ No

Please check any items below that pertain to your cardiovascular history:

- ☐ Heart attack (date: _____)
- ☐ Heart rhythm abnormalities
- ☐ Childhood heart defects
- ☐ Stroke (date: _____)
- ☐ Transient Ischemic Attack (TIA) (date: _____)
- ☐ Congestive heart failure (date: _____)
- ☐ Heart Murmur
- ☐ Peripheral Arterial Disease (PAD)

Please check any of the procedures below that you have had:

Procedure	Date (if known)	Procedure	Date (if known)
☐ 1) Heart catheterization	_____	☐ 7) Stents in vessels other than the heart	_____
☐ 2) Balloon/stent of heart	_____	☐ 8) Pacemaker	_____
☐ 3) Heart bypass surgery	_____	☐ 9) Internal Cardiac Defibrillator (ICD)	_____
☐ 4) Heart valve surgery	_____	☐ 10) EPS (Electrophysiologic Study)	_____
☐ 5) Carotid artery surgery	_____	☐ 11) Colonoscopy	_____
☐ 6) Leg vein bypass surgery	_____	☐ 12) Nuclear Stress Test	_____

Please complete the following information regarding your general medical/surgical history.
Check items below that pertain to you :

- ☐ Anemia
- ☐ Blood clots
- ☐ Cancer
- ☐ Glaucoma/cataracts
- ☐ Kidney disease/stones
- ☐ Pancreatic disease
- ☐ Seizures
- ☐ Tuberculosis(TB)
- ☐ Arthritis
- ☐ History of blood transfusions
- ☐ Emphysema/COPD
- ☐ Gout
- ☐ Liver disease/jaundice
- ☐ Pneumonia
- ☐ Sleep apnea
- ☐ Ulcers
- ☐ Asthma
- ☐ Esophageal reflux (GERD)
- ☐ Hepatitis
- ☐ Lung disease
- ☐ Prostate problems
- ☐ Stomach/colon cancer
- ☐ vein problems/stipping
- ☐ Bleeding disorder
- ☐ Bowel disorders
- ☐ Gallbladder disease
- ☐ Hormone Replacement
- ☐ Migraines
- ☐ Rhuematic fever
- ☐ Thyroid problems
- ☐ Other (please explain:) _____

_____

_____

Please list any surgeries, test, or illnesses not mentioned on prior page:

Significant surgery/illness/injuries	**Year:**

Social History

1.) What is your occupation? _____

2.) What is your marital status? _____

3.) How many children do you have? _____

4.) Do you exercise? Yes ___ No ___
If so, how often? _____

5.) Are you on a special diet? Yes ___ No ___
If so, please describe: _____

6.) Do you use caffeine? Yes ___ No ___
If so, how much? _____
Have you had any caffeine containing food/beverage or medicine (including coffee, decafeinated coffee, tea, chocolate, cocoa, exedrin, etc.) within the past 24 hours? Yes ___ No___

7.) Do you drink alcoholic beverages? Yes___ No ___
If so, how much? _____

Review of Systems: Please circle all items that pertain to you or circle NO PROBLEM.

General :	NO PROBLEM **OR**	Weight gain	Weight loss	Fatigue	Fever	
	other _____					
Skin:	NO PROBLEM **OR**	Rash				
	other _____					
Eyes :	NO PROBLEM **OR**	Recent changes in vision		or	vision loss	
	other _____					
Ears, nose & throat:	NO PROBLEM **OR**	Recent changes in hearing		or	hearing loss	
	other _____					
Heart & Blood vessels :	NO PROBLEM **OR**	Palpitations	Chest Discomfort		Fainting	
		Shortness of breath		Swelling of feet		Calf pain
	other _____					
Breathing & Lungs:	NO PROBLEM **OR**	Snoring	Chronic cough	Coughing up blood		
	other _____					
Stomach/ Digestion:	NO PROBLEM **OR**	Dark stools	Bleeding from rectum			
	other _____					
Urinary:	NO PROBLEM **OR**	Painful urination				
	other _____					
Muscles/bones :	NO PROBLEM **OR**	Joint stiffness	or	joint pain		
	other _____					
Hormonal :	NO PROBLEM **OR**	Intolerance to heat or cold				
	other _____					
Nerves/pain :	NO PROBLEM **OR**	Numbness	Weakness of Extremeties			
	other _____					
Bleeding problems :	NO PROBLEM **OR**	Easy bleeding	or	bruising		
	other _____					

Other complaints: _____

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Rex Winters, M.D., Inc.

RECORDS TRANSFER REQUEST

DATE: _____

TO: _____
(DOCTOR/HOSPITAL)

ADDRESS: _____

CITY: _____ STATE: _____

I hereby authorize the release of my _____
or copies of such and request that they be referred to:

Rex J. Winters, M.D., Inc.
DBA: HeartScape
Cardiovascular Center
of Orange County

PATIENT NAME: _____ DOB: _____

SIGNATURE: _____
(PATIENT, PARENT OR GUARDIAN)

HeartScape
Cardiovascular Center of Orange County

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HeartScape Cardiology is committed to protecting your health information. We will not release confidential medical information regarding your care to unauthorized persons. You have the right to request us to restrict use or disclosure of your health information, including information for treatment, payment or health care operations. HeartScape Cardiology has no obligation to agree to the request, but will review each request carefully.

NAME: _____ **MR#** _____

SSN# _____ **Date of Birth:** _____ **Date of Request:** _____

HeartScape Cardiology may:

1. **YES NO** Call my home, cell phone or pager and leave a message. Home# _____
   Cell# _____
   Pager# _____

2. **YES NO** Mail information to my home or alternate location.
   Alternate address: _____

3. **YES NO** Email information to me at: _____

4. Secondary contact person: Name _____ Relationship _____

5. **YES NO** HeartScape may review my information for purpose of research, audits and quality incentives.

I have the right to review the Notice of Privacy Practices prior to signing this consent. HeartScape reserves the right to revise its Notice of Privacy Practices at anytime.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, heartScape may decline to provide treatment to me.

My signature below constitutes my acknowledgement that HeartScape is a health care provider and may share my information for treatment, payment and health care operations and I am consenting to HeartScape's use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

_____ _____
Signature of Patient Date

If any person is physically unable to provide a signature or signs with a mark, print his/ her name of the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If patient is not capable of acknowledging the notice because of age or medical condition, complete the following:
Patient is a minor (____ years of age) or Patient is unable to acknowledge because _____

_____ _____
Signature of Patient Date

_____ _____ _____ _____
Witness Date Witness Date

For HeartScapes use only:
Patient did not sign due to: _____

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FINANCIAL POLICY

We file insurance claims for the following insurance plans with whom we are participating providers:

- Aetna
- Blue Cross of California
- Blue Shield of California
- Caremore
- Cigna Healthcare
- Coast Wise
- Great West Health Plan
- Los Alamitos IPA
- Medicare
- Memorial IPA
- Pacific Care
- Secure Horizon
- Southern California Preferred Providers
- Talbert Medical Group
- Tricare
- Triwest
- Union National
- United Healthcare
- Workers Compensation-City of Long Beach

If you are a member of one of these plans you must bring your insurance card, referral form (if applicable), and necessary co-payment to your appointment. If you do not obtain the required referral prior to your appointment, you will have the option of rescheduling your appointment or paying the charges in full at the time of service.

Patients who are not members of the above listed insurance plans are required to pay-in-full at the time of service. Please bring your insurance card to your appointment and we will provide you with an itemized claim form for you to submit to your insurance carrier.

Please understand that coverage varies significantly among the many insurance carriers. Therefore, it is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Awareness of the unique provisions of your policy will aid in meeting your deductible and limiting complicated paperwork for you.

Patients who are not covered by insurance are required to pay-in-full at the time of service. Special arrangements may be made depending on the amount of the balance due and your individual financial circumstances. Please contact our Patient Accounting Representative for more information.

Thank you,

Heartscape Cardiovascular Center of Orange County

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)

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We are requesting that you sign this form for our records. Having your signature on file enables us to submit Medicare and Medigap (Medicare Supplemental Insurance) claims and authorizes the Insurance Company to remit payment for our services directly to us; it also allows us to release copies of your medical records, if needed, to process claims.

Please read over the statement below and sign and date the section applicable to you. The top section applies if you only have Medicare. Sign both sections if you have Medicare and a supplemental insurance (Medigap).

MEDICARE AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts payment. I understand it is mandatory to notify the health care provider (physician) of any other party who may be responsible for paying for my treatment. (Section 11288 of the Social Security Act and 31 USG 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

SIGNATURE _____ DATE _____

MEDICARE AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release to: _____ (name of Medigap carrier) any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of the medical insurance benefits directly to the provider of HeartScape Cardiology Center of Orange County who accepts assignments.

The authorization applies to all occasions of service until it is revoked.

PATIENT SIGNATURE _____ DATE _____