PATIENT REGISTRATION FORM

PATIENT'S ACCOUNT #	GUARANTOR	CHART NUMBER	CATEGORY
NAME (LAST, FIRST INIT.)	HOME PHONE NO.	DATE OF BIRTH	DL#

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY NO.	SEX (M/F)	MARITAL STATUS	CELL PHONE NO.	WORK PHONE NO.

OCCUPATION	EMPLOYER	NATURE OF BUSINESS

EMPLOYER ADDRESS

EMPLOYER PHONE NO.	REFERRAL	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.

INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS

SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO

ANNUAL DEDUCTIBLE	DEDUCTIBLE MET	CO-PAYMENT	% OF COVERAGE	PAY PLAN

CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH
INSURED'S SEX (M/F)	INSURED'S PHONE NO.	INSURED'S SOCIAL SECURITY NO.

INSURED'S ADDRESS

INSURED'S EMPLOYER	EMPLOYER'S PHONE NO.

EMPLOYER'S ADDRESS

INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS

SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO

ANNUAL DEDUCTIBLE	DEDUCTIBLE MET	CO-PAYMENT	% OF COVERAGE	PAY PLAN

CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH
INSURED'S SEX (M/F)	INSURED'S PHONE NO.	INSURED'S SOCIAL SECURITY NO.

INSURED'S ADDRESS

INSURED'S EMPLOYER	EMPLOYER'S PHONE NO.

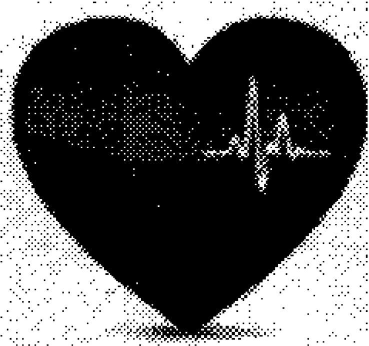
EMPLOYER'S ADDRESS

I authorize payment of medical benefits be made directly to the physician provider for services rendered.

DATE　　　　SIGNED (Insured or Authorized)

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information to this claim and the expenses reported.

DATE　　　　SIGNED (Insured or Authorized)



HEART RHYTHM SPECIALISTS OF CALIFORNIA INC.
CARDIOVASCULAR MEDICINE | CARDIAC ELECTROPHYSIOLOGY
SUKHVINDER BHAJAL, M.D.

REQUEST FOR PATIENT RECORDS

DATE: ____________________

PATIENT NAME: ______________________________ DATE OF BIRTH: ____________________

I AM AUTHORIZING SUKHVINDER BHAJAL, M.D. TO RECEIVE MEDICAL RECORDS FROM OTHER PARTIES TO ASSIST IN HIS TREATMENT WITH MY CARE.

____

____

____

____

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE YOUR OFFICE TO RELEASEANY TREATMENT INFORMATION REQUESTED INCURRED FOR THE TREATMENT SERVICES OF SUKHVINDER BHAJAL, M.D.

____

PATIENT (PARENT OR GUARDIAN IF MINOR) DATE

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS OF APRIL 14, 2003 ALL HEALTH CARE PROVIDERS ARE REQUIRED TO PROVIDE THEIR PATIENTS WITH A 'NOTICE OF PRIVACY PRACTICE STATEMENT. THE FOLLOWING IS A GENERIC NOTICE OF PRIVACY PRACTICE STATE DESIGNED TO PROVIDE YOU WITH AN IDEA OF WHAT YOU SHOULD EXPECT TO BE RECEIVING FROM YOUR HEALTH CARE PROVIDER.

HEART RHYTHM SPECIALISTS OF CA, INC
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 IT CAREFULLY.

HEART RHYTHM SPECIALISTS OF CALIFORNIA, INC., IS REQUIRED, BY LAW, TO MAINTAIN THE PRIVACY AND CONFIDENTIALITY OF YOUR PROTECTED HEALTH INFORMATION, AND TO PROVIDE OUR PATIENTS WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT

WE MAY DISCLOSE YOUR HEALTH CARE INFORMATION TO OTHER HEALTHCARE PROFESSIONALS WITHIN OUR PRACTICE FOR THE PURPOSE OF TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. (EXAMPLE)

> "ON OCCASION, IT MAY BE NECESSARY TO SEEK CONSULTATIONS REGARDING YOUR CONDITION FROM OTHER HEALTH CARE PROVIDERS ASSOCIATED WITH HEART RHYTHM SPECIALISTS OF CA, INC"
>
> "IT IS OUR POLICY TO PROVIDE A SUBSTITUTE HEALTH CARE PROVIDER, AUTHORIZED BY HEART RHYTHM SPECIALISTS OF CA INC. TO PROVIDE ASSESSMENT AND/OR TREATMENT TO OUR PATIENTS, WITHOUT ADVANCED NOTICE IN THE EVENT OF YOUR PRIMA.R.Y HEALTH CARE PROVIDER'S ABSENCE DUE TO VACATION, SICKNFSR, OTHER EMERGENCY SITUATION."

PAYMENT

WE MAY DISCLOSE YOUR HEALTH INFORMATION TOYOUR INSURANCE PROVIDER FOR THE PURPOSES OF PAYMENT OR HEALTH CARE OPERATIONS. (EXAMPLE)

> "AS A COURIESY TO OUR PATIENTS, WE WILL SUBMIT AN ITEMIZED BILLING STATEMENT TO YOUR INSURANCE CARRIER FOR THE PURPOSE OF PAYMENT TO HEART RHYTHM SPECIALISTS OF CA, INC. FOR HEALTH CARE SERVICES RENDERED. IF YOU PAY FOR YOUR HEALTH CARE SERVICES PERSONALLY, WE WILL, AS A COURTESY, PROVIDE AN ITEMIZED BILLING TO YOUR INSURANCE CARRIER FOR THE PURPOSE OF
>
> REIMBURSEMENT TO YOU. THE BILLING STA_______ I EMENT CONTAINS MEDICAL INFORMATION, INCLUDING DIAGNOSIS,
> DA TE OF INJURY OR CONDITION, AND CODES WHICH DESCRIBE THE HEALTH CARE SERVICES RECEIVED."

WORKER'S COMPENSATION

WE MAY DISCLOSE YOUR HEALTH INFORMATION AS NECESSARY TO COMPLY WITH STATE WORKER'S COMPENSATION LAWS.

EMERGENCIES

WE MAY DISCLOSE YOUR HEALTH INFORMATION TO NOTIFY OR ASSIST IN NOTIFYING A FAMILY MEMBER, OR ANOTHER PERSON RESPONSIBLE FOR YOUR CARE ABOUT YOUR MEDICAL CONDITION OR IN THE EVENT OF AN EMERGENCY OR OF YOUR DEATH.

PUBLIC HEALTH

AS REQUIRED BY LAW, WE MAY DISCLOSE YOUR HEALTH INFORMATION TO PUBLIC HEALTH AUTHORITIES FOR PURPOSES RELATED TO: PREVENTING OR CONTROLLING DISEASE, INJURY OR DISABILITY, REPORTING CHILD ABUSE OR NEGLECT, REPORTING DOMESTIC VIOLENCE REPORTING TO THE FOOD AND DRUG ADMINISTRATION PROBLEMS WITH PRODUCTS AND REACTIONS TO MEDICATIONS, AND REPORTING DISEASE OR INFECTION EXPOSURE.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

WE MAY DISCLOSE YOUR HEALTH INFORMATION IN THE COURSE OF ANY ADMINISTRATIVE OR JUDICIAL PROCEEDING.

LAW ENFORCEMENT

WE MAY DISCLOSE YOUR HEALTH INFORMATION TO A LAW ENFORCEMENT OFFICIAL FOR PURPOSES SUCH AS IDENTIFYING OR LOCATIONS A SUSPECT, FUGETIVE, MATERIAL WITNESS OR MISSING PERSON, COMPLYING WITH A COURT ORDER OR SUBPOENA, AND OTHER LAW ENFORCEMENT PURPOSES.

DECEASED PERSONS

WE MAY DISCLOSE YOUR HEALTH INFORMATION TO CORONERS OR MEDICAL EXAMINERS.

ORGAN DONATION

WE MAY DISCLOSE YOUR HEALTH INFORMATION TO ORGANIZATIONS INVOLVED IN PROCURING, BANKING, OR TRANSPLANTING ORGANS AND TISSUES.

RESEARCH

WE MAY DISCLOSE YOUR HEALTH INFORMATION TO RESEARCHERS CONDUCTING RESEARCH THAT HAS BEEN APPROVED BY AN INSTITUTIONAL REVIEW BOARD.

PUBLIC SAFETY

IT MAY BE NECESSARY TO DISCLOSE YOUR HEALTH INFORMATION TO APPROPRIATE PERSONS IN ORDER TO PREVENT OR LESSEN A SERIOUS AND IMMINENT THREAT TO THE HEALTH OR SAFETY OF A PARTICULAR PERSON OR TO THE GENERAL PUBLIC.

SPECIALIZED GOVERNMENT AGENCIES

WE MAY DISCLOSE YOUR HEALTH INFORMATION FOR MILITARY, NATIONAL SECURITY, PRISONER AND GOVERNMENT BENEFITS PURPOSES.

MARKETING

WE MAY CONTACT YOU FOR MARKETING PURPOSES OR FUNDRAISING PURPOSES, AS DESCRIBED BELOW:

(EXAMPLE): "AS A COURTESY TO OUR PATIENTS, IT IS OUR POLICY TO CALL YOUR HOME ON THE EVENING PRIOR TO YOUR SCHEDULED APPONTMENT TO REMIND YOU OF YOUR APPOINTMENT TIME IF YOU ARE NOT AT HOME, WE LEAVE A REMINDER MESSAGE ON YOUR ANSWERING MACHINE OR WITH THE PERSON ANSWERING THE PHONE. NO PERSONAL HEALTH INFORMATION WILL BE DISCLOSED DURING THIS RECORDING OR MESSAGE OTHER THAN THE 'DATE AND TIME OF YOUR SCHEDULED APPOINTMENT ALONG WITH A REQUEST TO CALL OUR OFFICE IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT."

"IT IS OUR PRACTICE TO PARTICIPATE IN CHARITABLE EVENTS TO RAISE AWARENESS, FOOD DONATIONS, GIFTS, MONEY, ETC DURINGTHESE TIMES, WE MAY SEND YOU A LETTER, POST CARD, INVITATION OR CALL YOUR HOME TO INVITE YOU TO PARTICIPATE IN THE CHARITABLE ACTIVITY. WE WILL PROVIDE YOU WITH INFORMATION ABOUT THE TYPE OF ACTIVITY, THE DATES AND TIMES, AND REQUEST YOUR PARTICIPATION IN SUCH AN EVENT. IT IS NOT OUR POLICY TO DISCLOSE ANY PERSONAL HEALTH INFORMATION ABOUT YOUR CONDITION FOR THE PURPOSE OF COMEAU HEALTH CARE ASSOCIATES SPONSORED FUND-RAISING EVENTS."

CHANGE OF OWNERSHIP

IN THE EVENT THAT HEART RHYTHM SPECIALISTS OF CA, INC IS SOLD OR MERGED WITH ANOTHER ORGANIZATION, YOUR HEALTH INFORMATION/RECORD WILL BECOME THE PROPERTY OF THE NEW ORDER

YOUR HEALTH INFORMATION RIGHTS

- YOU HAVE THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION. PLEASE BE ADVISED, HOWEVER, THAT HEART RHYTHM SPECIALISTS OF CA, INC IS NOT REQUIRED TO AGREE TO THE RESTRICTION THAT YOU REQUESTED.

- YOU HAVE THE RIGHT TO HAVE YOUR HEALTH INFORMATION RECEIVED OR COMMUNICATED THROUGH AN ALTERNATIVE METHOD OR SENT TO AN ALTERNATIVE LOCATION OTHER THAN THE USUAL METHOD OF COMMUNICATION OR DELIVERY, UPON YOUR REQUEST.

- YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION.

- YOU HAVE A RIGHT TO REQUEST THAT HEARTH RHYTHM SPECIALISTS OF CA, INC AMEND YOUR PROTECTED HEALTH INFORMATION. PLEASE BE ADVISED, HOWEVER, THAT HEART RHYTHM SPECIALISTS OF CA, INC. IS NOT REQUIRED TO AGREE TO AMEND YOUR PROTECTED HEALTH INFORMATION. IF YOUR REQUEST TO AMEND YOUR HEALTH INFORMATION HAS BEEN_DENIED, YOU WILL BE PROVIDED WITH AN EXPLANATION OF OUR DENIAL REASON(S)AND INFORMATION ABOUT HOW YOU CAN DISAGREE WITH THE DENIAL.

- YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION MADE BY HEART RHYTHM SPECIALISTS OF CA, INC.

- YOU HAVE A RIGHT TO A PAPER COPY OF THIS NOTICE OF PRIVACY PRACTICES AT ANY TIME UPON REQUEST.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICE

HEART RHYTHM SPECIALISTS OF CA INC.RESERVES THE RIGHT TO AMEND THIS NOTICE OF PRIVACY PRACTICE AT ANY TIME IN THE FUTURE, AND WILL MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INFORMATION THAT IT MAINTAINS. UNTIL SUCH AMENDMENT IS MADE HEART RHYTHM SPECIALISTS OF CA INC. IS REQUIRED BY LAW TO COMPLY WITH THIS NOTICE.

HEART RHYTHM SPECIALISTS OF CA INC. IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF ITS LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR HEALTH INFORMATION. IF YOU HAVE QUESTIONS ABOUT ANY PART OF THIS NOTICE OR IF YOU WANT MORE INFORMATION ABOUT YOUR PRIVACY RIGHTS PLEASE CONTACT US BY CALLING OFFICE AT 559-635-4800. IF PRACTICE PRIVACY OFFICER IS NOT AVAILABLE, YOU MAY MAKE AN APPOINTMENT FOR A PERSONAL CONFERENCE IN PERSON OR BY TELEPHONE WITHIN 2 WORKING DAYS.

COMPLAINTS

COMPLAINTS ABOUT YOUR PRIVACY RIGHTS, OR HOW HEART RHYTHM SPECIALISTS OF CA INC. HAS HANDLED YOUR HEALTH INFORMATION SHOULD BE DIRECTED TO THE OFFICE MANAGER BY CALLING THIS OFFICE AT 559- 635-4800. IF THE OFFICE MANAGER IS NOT AVAILABLE, YOU MAY MAKE AN APPOINTMENT FOR A PERSONAL CONFERENCE IN PERSON OR BY TELEPHONE WITHIN 1 WORKING DAYS.

IF YOU ARE NOT SATISFIED WITH THE MANNER IN WHICH THIS OFFICE HANDLES YOUR COMPLAINT. YOU MAY SUBMIT A FORMAL COMPLAINT TO:

DHHS, OFFICE OF CIVIL RIGHTS
200 INDEPENDENCE AVENUE S.W.
WASHINGTON, DC 20201

THIS NOTICE IS EFFECTIVE AS OF ______________________________

I HAVE READ THE PRIVACY NOTICE AND UNDERSTAND MY RIGHTS CONTAINED IN THIS NOTICE.

BY WAY OF MY SIGNATURE, I PROVIDE HEART RHYTHM SPECIALISTS OF CA, INC. WITH MY AUTHORIZATION AND CONSENT TO USE AND DISCLOUSE MY PROTECTED HEALTH CARE INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONSAS DESCRIBED IN THIS PRIVACY NOTICE.

____

PATIENTS NAME (PRINT)

____

PATIENTS SIGNATURE DATE

____

AUTHORIZED FACILITY SIGNATURE DATE

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.

Co-payments are due at time of service.

- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to (PROVIDER OR GROUP NAME) on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Heart Rhythm Specialists of Ca to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Heart Rhythm Specialists of Ca. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

____

[redacted] Date

____

[redacted] Relationship to Patient