East Bay Cardiovascular and Thoracic Associates

1320 El Capitan Drive, Suite 120, Danville, CA 94526
2350 Pacheco Street, Concord, CA 94520
5565 West Las Positas Blvd, Suite 340, Pleasanton, CA 94588

Financial Agreement

Thank you for choosing East Bay Cardiovascular and Thoracic Associates as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. A clear understanding of our Financial Policy is an important part of that relationship. Please understand that payment for services is a part of your responsibility as a patient. If you have any questions regarding our fees, policies, or your responsibility, please ask. It is your responsibility to notify our office of any changes to patient information including address, name, or insurance coverage.

Covered Entities

East Bay Cardiovascular and Thoracic Associates ("EBCVT") and Excelsior Surgery Center ("Excelsior ASC") are separate legal entities that work closely together to provide coordinated patient care. For purposes of this Financial Agreement, references to "the Practice," "we," "us," or "our" refer collectively to East Bay Cardiovascular and Thoracic Associates and Excelsior Surgery Center.

This Financial Agreement applies to all professional services, facility services, procedures, and related care provided by ***EBCVT and/or Excelsior Surgery Center****.*

Co-pays:
Patients are required to present a valid insurance card at each visit. All co-payments and past-due balances are due at the time of check-in unless prior arrangements have been made with our billing department. We accept cash, checks, and credit cards. Post-dated checks are not accepted.

Insurance Claims:
Insurance is a contract between you and your insurance company; in most cases, EBCVT is not a party to that contract. As a courtesy, we will submit claims to your primary insurance company. To ensure accurate billing, you must provide complete and current insurance information, including primary and secondary coverage, and notify us of any changes. While we may estimate your insurance benefits, final payment determinations are made by the insurance company. If your insurance plan is not contracted with EBCVT, you are responsible for any charges not covered by insurance, including amounts exceeding the usual and customary allowance. If EBCVT is out-of-network and your insurance company sends payment directly to you, you agree to forward payment to our office immediately.

> ***A quote of benefits and/or authorization does not guarantee payment. Payment is subject to all terms, conditions, limitations, and exclusions of the member's insurance contract in effect at the time of service.***

Participating Insurances:
If your insurance plan is one with which EBCVT does NOT participate, payment in full is required.

A list of participating insurance plans is provided on the back of this form. Please note that not all EBCVT providers may be contracted or in-network, even if the practice participates with your insurance. It is the patient's responsibility to verify provider participation prior to the visit.

Referrals and Prior Authorizations:
Certain insurance plans (HMO, POS, etc.) require referrals and/or prior authorization from your Primary Care Provider (PCP) before seeing a specialist. If required, it is your responsibility to obtain the appropriate referral and/or authorization. Failure to do so may result in reduced or denied payment by your insurance company, and the remaining balance will be your responsibility. Appointments may need to be rescheduled or alternative payment arrangements made if authorization is not obtained.

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Participating Insurance Plans

- AARP/UHC
- AARP Supplemental
- Aetna POS, PPO HMO
- Aetna Medicare Managed
- Affinity Medical Group (based on provider)
- Anthem Blue Cross PPO
- Anthem Blue Cross HMO
- Blue Shield of California PPO, HMO
- Blue Shield Federal
- Blue Out of State
- Blue Shield 65 plus
- California Iron Workers (Union) BC plan
- Carpenters Health & Welfare (Union) BC plan
- Contra Costa Health Plan (CCHP) Medi Cal plan
- Contra Costa Health Plan Basic plan
- Contra Costa Health Plan Medicare Managed
- Contra Costa Health CCN plan
- Cigna PPO, POS, HMO
- Cigna Medicare Managed
- Delta Health Systems
- Eastbay Drayage Drivers (Union) BC plan
- First Health (Third party)
- Health Net PPO, HMO
- Health Net Medicare Managed
- Health Plan of San Joaquin (Medi-Cal plan)
- Hill Physicians Medical Group
- Humana PPO
- Humana Supplemental
- John Muir IPA
- John Muir Network Select POS plan
- Laborers Health and Welfares (Union) BC plan
- Medi-Cal
- Medicare
- Medicare Railroad
- Northern Ca Bakery Drivers (Union) BC plan
- Operating Engineers (Union) BC plan
- Partnership Health Plan (RAF required)
- Scan PPO Medicare Managed
- Sheet Metal Workers (Union) BS plan
- State Compensation (Workers Comp)
- Sutter Select/UMR
- Teamsters Benefit Trust (Union) BC plan
- Tricare West region only
- UMR
- United HealthCare PPO, HMO
- United HealthCare Medicare Managed
- UFCW (Union) BS plan
- VA (referral only)
- Workers Comp

Medical Records:
Please allow **5–7 business days** to process medical record requests.

For **EDD/FMLA forms,** please allow **5–7 business days from the date of hospital discharge** to complete your request.

Every effort will be made to complete requests as promptly as possible. If your request is completed before the standard timeframe, you will be notified. If you have an urgent need, please inform us at the time of your request.

Fees associated with medical records are listed below and on the back of this form.

Medical Records Price List

Patients Requests:
$10 – 10 to 20 pages
$15 – 21 to 49 pages
$20 – 50+ pages

EDD/FMLA Forms:
$20 – Initial EDD/FMLA forms
$10 – Each additional EDD/FMLA form
$5 – Burning of CD's

Attorneys and Insurance Companies: $25 - Medical records and/or itemized billing

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Self-pay Accounts:

Self-pay accounts include patients without insurance coverage, patients enrolled in insurance plans with which EBCVT does not participate, patients without a valid insurance card on file, and liability cases. We do not accept attorney letters or contingency-based payment arrangements. It is the patient's responsibility to verify whether EBCVT participates with their insurance plan. If there is a discrepancy between the patient's information and our records, the patient will be considered self-pay until coverage is verified.

Payment in full is due at the time of service for all self-pay patients. If needed, payment arrangements may be discussed with a billing coordinator prior to or at the time of the visit.

Our goal is to provide excellent care while minimizing financial stress whenever possible.

Motor Vehicle Accident (MVA) and Third-Party Billing:

EBCVT does not bill third-party liability insurers (including auto or homeowner's insurance). Our financial relationship is with you, the patient, not with any third-party insurer. You are responsible for seeking reimbursement directly from them.

At your request, we will submit claims to your primary health insurance carrier. Your insurance company may require you to complete an accident questionnaire. Failure to complete and return this questionnaire, or denial of the claim, will result in the patient being responsible for payment in full.

Workers' Compensation:

It is the patient's responsibility to provide employer authorization and workers' compensation claim information at the time of service. If the workers' compensation claim is denied, the balance becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier along with documentation of the workers' compensation denial. If your primary insurance denies the claim, you will be responsible for payment in full.

Missed Appointments:

EBCVT requires **48-hour notice** for appointment cancellations. Appointments missed without prior notice may be charged a **$50.00 no-show fee**.

For scheduled procedures at Excelsior Surgery Center, failure to cancel with appropriate notice may result in a $100.00 no-show or late cancellation fee, due to reserved operating room time, staffing,and facility resources.

Returned Checks:

A $25.00 returned check fee will be applied to your account and must be paid by cash or money order, in addition to the original amount due. Patients may be placed on a cash-only basis following any returned check.

Minors:

The parent(s) or legal guardian(s) are financially responsible for all services provided to minors and will receive all billing statements. A signed consent to treat may be required for unaccompanied minors.

Outstanding Balance Policy:

Past-due accounts will receive three billing statements. If payment is not received, one phone call will be made to attempt to establish payment arrangements. If no resolution is reached, the account may be referred to a collection agency or attorney, and the patient may be discharged from the practice.

If an account is sent to collections, the financially responsible party will be responsible for all collection costs, including attorney fees and court costs.

Regardless of any personal or third-party arrangements, patients 18 years of age or older are ultimately responsible for payment of services rendered. EBCVT will not bill other individuals or parties.

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Financial Agreement Acknowledgement

This Financial Policy is intended to help our office provide quality care to our valued patients. If you have any questions or require clarification regarding any of the above policies, please contact our office.

By signing below, the undersigned acknowledges that he/she has read, understands, and agrees to the financial obligations and all other applicable provisions outlined above, and that a copy of this Financial Agreement has been received.

The undersigned further represents and warrants that he/she is either the patient, the patient's legal representative, or is otherwise duly authorized as the patient's general agent to execute this agreement and accept its terms on the patient's behalf.

If the undersigned is not the patient, the undersigned agrees to be financially responsible for charges incurred by the patient that are not covered by insurance, unless otherwise prohibited by law.

_____

Signature of Patient or Legally Authorized Representative Date

_____

Printed Name of Signer Relationship to Patient (if not self)

_____

EBCVT Witness Date

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NOTICE OF PRIVACY PRACTICES

Privacy Officer: Jessica Freitas, Practice Administrator (or designee), (925) 676-2600
This Privacy Officer serves both East Bay Cardiovascular and Thoracic Associates and Excelsior Surgery Center.

Effective Date: January 2026

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.

East Bay Cardiovascular and Thoracic Associates ("EBCVT") and Excelsior Surgery Center ("Excelsior ASC") are separate legal entities that work closely together to provide coordinated care. Each entity is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and is committed to maintaining the privacy and security of your protected health information.

For purposes of this Notice of Privacy Practices, references to "we," "us," or "our" refer collectively to EBCVT and Excelsior ASC unless otherwise specified.

We create and maintain records of the care and services you receive, and we may receive records from other healthcare providers. We use this information to provide quality care, obtain payment for services, and comply with legal and professional obligations.

We are required by law to:

- *Maintain the privacy of your protected health information (PHI)*
- *Provide you with this Notice of Privacy Practices*
- *Follow the terms of this Notice currently in effect*

This Notice explains how we may use and disclose your medical information, your rights regarding that information, and our responsibilities. If you have questions, please contact the Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

Your medical record is the property of this medical practice, but the information in it belongs to you. Federal and California law allow us to use and disclose your health information for the following purposes:

1. **Treatment** - We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured. We may share your protected health information between EBCVT and Excelsior ASC as necessary for treatment, payment, and healthcare operations, as permitted by law.
2. **Payment** - We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. **Healthcare Operations** - We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect

the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. ***We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.***

4. **Appointment Reminders** - We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. **Sign In Sheet -** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family** - We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing** - Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,

   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

   Sale of Health Information - We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
8. **Required by Law** - As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
9. **Public Health -** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult 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. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. **Health Oversight Activities** - We may and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
11. **Judicial and Administrative Proceedings** - We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
12. **Law Enforcement** - We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identification of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
13. **Coroners** - We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
14. **Organ or Tissue Donation** - We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
15. **Public Safety** - We may, and are sometimes required by law, 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 the general public.
16. **Proof of Immunization** - We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
17. **Specialized Government Functions** - We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
18. **Worker's Compensation** - We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
19. **Change of Ownership** - In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
20. **Breach Notification** - In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections** - You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.
2. **Right to Request Confidential Communications** - You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy** - You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe

allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. **Right to Amend or Supplement** - You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. **Right to an Accounting of Disclosures** - You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.
After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. **We will also post the current notice on our website.**

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with:

U.S. Department of Health & Human Services
Office for Civil Rights - Region IX
San Francisco, CA 94103

You will not be penalized for filing a complaint.

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Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- ***How this office will use and disclose your protected health information.***
- ***Your privacy rights with regard to your protected health information.***
- ***This office's obligations concerning the use and disclosure of your protected health information.***

I acknowledge that I have received a copy of the Notice of Privacy Practices for East Bay Cardiovascular and Thoracic Associates and Excelsior Surgery Center. I understand that this Notice describes how my protected health information may be used and disclosed and how I can access this information.

If I am signing on behalf of the patient, I represent and warrant that I am the patient's legally authorized representative or am otherwise authorized to receive protected health information on the patient's behalf.

_____

Signature of Patient or Legally Authorized Representative Date

_____

Printed Name of Signer Relationship to Patient (if not self)

_____

EBCVT Witness Date

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
Authorization and Communication Preferences

(To be updated every two (2) years or upon request)

I authorize **East Bay Cardiovascular and Thoracic Associates ("EBCVT") and Excelsior Surgery Center ("Excelsior ASC")**, individually and collectively, to use and disclose my protected health information as described below.

AUTHORIZATION TO DISCUSS AND RELEASE MEDICAL INFORMATION

I authorize EBCVT and Excelsior ASC to discuss and/or release my medical information to:

- ☐ Patient Only
- ☐ Other (print name(s)): _____
  Relationship to patient: _____ Telephone: (___) _____

AUTHORIZATION TO DISCUSS AND RELEASE FINANCIAL/BILLING INFORMATION

I authorize EBCVT and Excelsior ASC to discuss and/or release billing and financial information related to my care to:

- ☐ Patient Only
- ☐ Other (print name(s)): _____
  Relationship to patient: _____ Telephone: (___) _____

(Authorization to receive financial information does not establish financial responsibility unless otherwise agreed in writing.)

COMMUNICATION PREFERENCES

I authorize EBCVT and/or Excelsior ASC to leave **detailed messages** regarding my medical care and/or appointments on my answering machine or voicemail service.

☐ YES ☐ NO

NOTICE OF PRIVACY PRACTICES & USE OF INFORMATION

I acknowledge that I have received a copy of East Bay Cardiovascular & Thoracic Associates' Notice of Privacy Practices, which describes how my protected health information may be used and disclosed for treatment, payment, and healthcare operations, as permitted by law.

I understand that I may request restrictions on the use or disclosure of my protected health information; however, EBCVT is not required to agree to such requests unless required by law. I understand that I may revoke this authorization in writing at any time. Revocation will not affect information already used or disclosed prior to receipt of the written revocation. This authorization will remain in effect unless revoked in writing.

OUR COMMITMENT TO PRIVACY

EBCVT is committed to protecting the privacy and security of patient information and complies with all applicable HIPAA regulations, including:

- Safeguarding medical and billing records
- Limiting access to authorized individuals
- Providing patients appropriate access to their records
- Maintaining privacy and billing practices consistent with national standards

_____

Signature of Patient or Legally Authorized Representative Date

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_____

Printed Name of Signer Relationship to Patient (if not self) Date

NEW PATIENT QUESTIONNAIRE

Print Name: _____ DOB: _____ Height: _____ Weight: _____

Pharmacy: _____ Pharmacy Location/Phone Number: _____

Current or past occupation: _____

Dialysis Location: _____ Phone number: _____

Dialysis Days / Frequency: _____

Nephrologist: _____ Phone: _____

MEDICAL HISTORY:

- ☐ Heart Attack
- ☐ Kidney Disease
- ☐ Headaches
- ☐ Acid Reflux / Gerd
- ☐ Heart Failure (CHF)
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐ Stomach Ulcers
- ☐ Heart Rhythm Problems
- ☐ Back Problems
- ☐ Asthma
- ☐ Psychiatric Illness
- ☐ High Blood Pressure
- ☐ Neck Problems
- ☐ COPD
- ☐ Substance Abuse
- ☐ Diabetes
- ☐ Arthritis
- ☐ Lung Problem
- ☐ Thyroid Disorder
- ☐ Gout
- ☐ Sleep Apnea
- ☐ Clotting Disorder
- ☐ Stroke / Mini Stroke
- ☐ Liver Disease
- ☐ Anesthesia Complications
- ☐ Other:_____

- ☐ Family history of aneurysms, bleeding, or clotting disorders
- ☐ Family history of anesthesia complications
- ☐ Other significant family medical conditions:_____
  _____

SURGICAL HISTORY: *Please list all operations and approximate date*

_____

_____

- ☐ Defibrillator
  Make/Model: _____
  Implantation Date: _____
- ☐ Pacemaker
  Make Model: _____
  Implantation Date: _____

SOCIAL HISTORY:

Tobacco:

- ☐ Never
- ☐ Former
  Quit date: _____
  Number of years: _____
- ☐ Current
  Packs per day: _____
  Number of years: _____
- ☐ Chew
  Number of years: _____
- ☐ Pipe
  Number of years: _____

Alcohol:

- ☐ None
- ☐ Occasionally
  glasses per (week / month) _____
- ☐ Daily
  glasses per day _____

Current or past drug use:

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☐ Yes _____

☐ No

Please continue on back →

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ACTIVITY:

- ☐ Limited mobility
- ☐ Moderate activity
- ☐ Exercise weekly
- ☐ Exercise daily

Can you walk up a flight of stairs without difficulty?

- ☐ Yes
- ☐ No

CURRENT SYMPTOMS:

- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Leg swelling
- ☐ Fever
- ☐ Heavy snoring
- ☐ Leg ulcers
- ☐ Chills
- ☐ Abdominal pain
- ☐ Leg color change
- ☐ Chest pain
- ☐ Constipation
- ☐ Numbness
- ☐ Palpitations
- ☐ Diarrhea
- ☐ One-sided weakness
- ☐ Exercise limitation
- ☐ Easy bleeding
- ☐ One-sided vision loss
- ☐ Pain with walking
- ☐ Easy bruising
- ☐ Memory loss
- ☐ Erectile dysfunction
- ☐ Nosebleeds
- ☐ Word finding difficulties
- ☐ Recent infectious exposure
- ☐ Dental problems
- ☐ Headaches
- ☐ Cough
- ☐ Varicose veins
- ☐ Other:_____

ALLERGIES:

Please list medication and food allergies including reaction

_____

_____

☐ Contrast Agents ☐ Latex ☐ Iodine

MEDICATION LIST:

*Please **bring, list, or attach** all prescription medications, over-the-counter medications, vitamins, or herbal supplements you are currently taking. **Your accuracy is critical.***

Medication:	*Dose:*	*Frequency:*

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Patient Information

Name: _____
Last First Middle

Gender: Male \ Female Date of Birth: _____ Social Security Number (SSN): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Home _____ Cell _____ Other _____

Email Address: _____

Emergency Contact

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Primary Care Physician _____ **Referring Physician** _____

Insurance Information

Primary Insurance_____ ID#_____ Grp#_____

Subscriber Name_____ Relationship to Subscriber _____

Secondary Insurance_____ ID#_____ Grp#_____

Subscriber Name_____ Relationship to Subscriber _____

I certify that the information above is correct. I agree that insurance benefits for East Bay Cardiovascular and Thoracic Associates provider charges payable to the insured are made payable to East Bay Cardiovascular and Thoracic Associates and that physician benefits otherwise payable to the insured are to be made payable to East Bay Cardiovascular and Thoracic Associates. Any payments received for services rendered to me by East Bay Cardiovascular and Thoracic Associates may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I acknowledge that I am fully responsible for all non-covered services, deductibles and co-payments. I further agree, in the event of default due to non-payment, to be responsible for collection fees, court costs and/or legal fees.

_____
Signature of Patient or Legally Authorized Representative Date

_____
Printed Name of Signer Relationship to Patient (if not self) Date