Margaret Leila Rasouli, M.D., Inc.
Diplomate, American Board of Internal Medicine
Cardiovascular Disease, Interventional
Cardiology and Nuclear Cardiology

CARDIOCARE OC

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (electrocardiogram, echocardiogram etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives her the chance to check my condition and response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor If I Decide *Not* to Follow Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow her recommendations so that she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite your, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Name	Patient Signature	Date
M.L. Rasouli		
Physician Name	Physician Signature	Date

Margaret Leila Rasouli, M.D., Inc
DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE
CARDIOVASCULAR DISEASE, INTERVENTIONAL
CARDIOLOGY AND NUCLEAR CARDIOLOGY

Patient Name:_____

DOB:_____

Date:_____

PATIENT INTRODUCTION

Name:_____ Date of Birth:_____ Age:_____
(Last) (First) (Middle)

Home Address:_____
(Street) (Apt. No.) (City) (State) (Zip Code)

Home Ph:_____ Cell Ph:_____ Other Ph:_____

Driver's License #:_____ Social Security #:_____ Gender:____Male____Female

E-Mail Address:_____ Allergies:_____

Marital Status:___Single ___Married___Widowed___Divorced Ethnicity:___Hispanic ___Non-Hispanic ___Patient Refusal

Primary Language:_____ Secondary Language: _____

Race:_____Asian_____American Indian/Alaska Native_____Black/African American_____Hawaiian/Other Pacific

Islander_____White_____Patient Refusal_____Other Race_____

EMPLOYER INFORMATION

Employer:_____ Occupation:_____ Work Phone#:_____

Employer Address:_____
(Street) (City) (State) (Zip Code)

REFERRAL INFORMATION

Referring Physician:_____ Phone No:_____

Primary Care Physician (PCP):_____ Phone No:_____

Other Physician:_____ Phone No:_____

EMERGENCY CONTACT INFORMATION *(person not living with you)*

Name:_____ Relationship_____ HIPPA Consent:____Yes____No

Address:_____
(Street) (Apt. No.) (City) (State) (Zip Code)

Home Ph:_____ Cell Ph:_____ Other Ph:_____

Margaret Leila Rasouli, M.D., Inc
DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE
CARDIOVASCULAR DISEASE, INTERVENTIONAL
CARDIOLOGY AND NUCLEAR CARDIOLOGY

Patient Name:_____

DOB:_____

Date:_____

SPOUSE INFORMATION OR RESPONSIBLE PARTY INFORMATION IF PATIENT IS A MINOR

Name:_____ Date of Birth:_____ Age:_____
(Last) (First) (Middle)

Home Address:_____
(Street) (Apt. No.) (City) (State) (Zip Code)

Home Ph:_____ Cell Ph:_____ Driver's License #:_____

Social Security #:_____ E-Mail Address:_____ Gender:___Male___Female

PHARMACY INFORMATION

Pharmacy Name:_____ Phone:_____

Address:_____
(Street) (City) (State) (Zip Code)

PRESCRIPTION INSURANCE INFORMATION

Subscriber Name: _____ RX Insurance Name:_____

Insurance Policy No:_____ Phone:_____

MEDICAL INSURANCE INFORMATION

Subscriber Name: _____ Insurance Name:_____

Insurance Policy No:_____ Group No. _____

Claims Mailing Address:_____
(Street/P.O. Box) (City) (State) (Zip Code)

Secondary Insurance:
Name of Insured: _____ Name of Insurance:_____

Insurance Policy No:_____ Group No. _____

Claims Mailing Address:_____
(Street/P.O. Box) (City) (State) (Zip Code)

PATIENT (SELF) CARDIOVASCULAR HEALTH HISTORY

Date: _____

Name: _____
First Last MI

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Present or Retired Occupation: _____ Marital Status: _____

Current Medical Symptoms / Complaints: _____

_____

_____

List Allergies (Medicines, Foods, Etc.): _____

_____

Please List all Medications (include dose & how it is taken):

NAME OF MEDICATION	DOSEAGE	HOW / WHEN TAKEN

Please List Operations:

1.	5.
2.	6.
3.	7.
4.	8.

FAMILY HISTORY:

If family members are living, list health problems and their ages. If deceased, please give age and cause of death.

MOTHER	FATHER	SISTERS	BROTHERS

If there are close relatives with a history of heart disease, high cholesterol, high blood pressure, stroke, diabetes, cancer, etc., please indicate their relationship, specific medical condition and their age:

_____

_____

SOCIAL HISTORY:

Do you Smoke? ☐ Yes ☐ No If Yes, how much per day? _____

Have you ever Smoked? ☐ Yes ☐ No If Yes, for how many years? _____

If you stopped Smoking, how long ago? _____ What age did you start? _____

Do you drink Alcohol? ☐ Yes ☐ No If Yes, how many drinks per week? _____

If you have stopped drinking, how long ago? _____

If you are exercising, please list the type of exercise, frequency, and duration (e.g., walking 3 times per week for 20 minutes): _____

_____

Do you follow a special diet? ☐ Yes ☐ No ☐ Low Salt ☐ Low Fat ☐ Low Cholesterol

Other: _____

What was your last cholesterol level? _____ Date Taken: _____

RISK FACTORS (Please check all that apply):

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Overweight

☐ Undue Stress ☐ Previous Heart Attack ☐ Peripheral Vascular Disease

☐ Post Menopausal

If Female, are you still menstruating? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No

If No, do you still use Birth Control? ☐ Yes ☐ No

Date of Last Chest X-Ray: _____

Date of Last EKG: _____

Other: _____

REVIEW OF SYSTEMS:

Chest Pain at Rest	☐ Yes	☐ No	Date Began: _____
Chest Pain Exercising	☐ Yes	☐ No	Date Began: _____
Palpitations (Heart Pounding, Racing)	☐ Yes	☐ No	Date Began: _____
Short of Breath at Night / Lying Down	☐ Yes	☐ No	Date Began: _____
At Rest	☐ Yes	☐ No	Date Began: _____
Exercising	☐ Yes	☐ No	Date Began: _____
Calf / Leg Pain with Ambulation	☐ Yes	☐ No	Date Began: _____
Rheumatic Fever	☐ Yes	☐ No	Date Began: _____
Rheumatic Heart Disease	☐ Yes	☐ No	Date Began: _____
Heart Murmur	☐ Yes	☐ No	Date Began: _____
Swelling of Feet or Ankles (Edema)	☐ Yes	☐ No	Date Began: _____
Congestive Heart Failure	☐ Yes	☐ No	Date Began: _____
Dizziness	☐ Yes	☐ No	Date Began: _____
Fainting	☐ Yes	☐ No	Date Began: _____
Cough with or without Sputum	☐ Yes	☐ No	Date Began: _____
Nausea / Vomiting	☐ Yes	☐ No	Date Began: _____
Bloody or Black Stool	☐ Yes	☐ No	Date Began: _____
Hepatitis or Jaundice	☐ Yes	☐ No	Date Began: _____
Easy Bruising or Bleeding	☐ Yes	☐ No	Date Began: _____
Thyroid Disorder	☐ Yes	☐ No	Date Began: _____
Lung Disease _____	☐ Yes	☐ No	Date Began: _____
Kidney Disease	☐ Yes	☐ No	Date Began: _____
Stroke	☐ Yes	☐ No	Date Began: _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____
Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: _____
Address of Provider: _____
_____

Fax Number: _____
_____

Recipient and Address for Delivery of Records:

Purpose: I understand that the specific purpose of this Authorization is

_____

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

☐ All of my health information described above except for the following:

_____

☐ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

_____

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.

Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have a right to receive a copy of this authorization from my health care provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____ _____ _____

Signature Date Signature of Witness

Name: _____

(Please Print)

If Individual is unable to sign this Authorization, please complete the information below.

_____ _____ _____ _____

Signature of Personal Representative Legal Relationship Date Witness Signature

Name: _____

(Please Print)

BST99 1402235-1.009900.0021

Authorization form

Office of

Margaret Leila Rasouli, M.D

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Margaret Leila Rasouli, M.D** to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits **Margaret Leila Rasouli, M.D** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

I do not have to sign this authorization in order to receive treatment from, **Margaret Leila Rasouli, M.D** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer:

Margaret Leila Rasouli, M.D
24411 Health Center Dr # 650
Laguna Hills, CA 92653

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Margaret Leila Rasouli, M.D., Inc
Diplomate, American Board of Internal Medicine
Cardiovascular Disease, Interventional
Cardiology and Nuclear Cardiology

Patient Name:_____

DOB:_____

Date:_____

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Margaret Leila Rasouli, M.D., Inc. appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill including but not limited to deductible, co-payment and co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance carrier.

I have read the above policy regarding my financial responsibility to Margaret Leila Rasouli, M.D., Inc. for providing services to me or the above named patient. I hereby authorize Margaret Leila Rasouli, M.D., Inc. to provide medical care and to release my medical information to my insurance company(s) as necessary for the payment of benefits. I also authorize my insurance company(s) to pay benefits directly to Margaret Leila Rasouli, M.D., Inc. These authorizations remain valid and effective from the date of signing until revoked in writing. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I further agree that a photocopy of this agreement shall be as valid as the original.

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Margaret Leila Rasouli, M.D., Inc., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I further authorize Margaret Leila Rasouli, M.D., Inc. to release any information acquired in the course of my or the above named patient's examination and treatment to any/all appropriate agencies.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize Margaret Leila Rasouli, M.D., Inc. to view my external prescription history via Surescripts Prescription Service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan. I certify that I read and understand the scope of my consent and that I authorize the access.

CONSENT TO CONTACT VIA EMAIL

To the extent that our new Electronic Medical Record software allows it, we may be able to contact you via email to remind you of appointments or to share other pertinent information about your healthcare. I authorize Margaret Leila Rasouli, M.D., Inc. to use the email address I provided above to contact me in regard to my healthcare. I consent that protected healthcare information may be transmitted to me via the email address I provide.

MISSED APPOINTMENT POLICY

I understand that Margaret Leila Rasouli, M.D., Inc. does REQUIRE 24 hours advanced notice to cancel or re-schedule an appointment. I understand a fee may be charged to my account for missed appointments.

REQUESTS

I understand that Margaret Leila Rasouli, M.D., Inc. may charge a fee for any record requests, letter requests and form fill-out requests.

_____ _____

(Signature) (Date)

Margaret L. Rasouli, M.D.
24411 Health Center Drive #650
Laguna Hills CA 92653
P: (949) 600-7228| F: (949) 600-7229

Notice of Privacy Practices Acknowledgment

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of your Notice of Privacy Practice. This notice explains your rights, our legal duties and our privacy practices. It also describes how much medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice:

- Our Pledge
- Your personal information
- Our Privacy Practices
- Your written permission
- Other restrictions
- Your rights
- Changes
- Questions or Complaints

We may use your information for:

- Treatment
- Health Information Exchange
- Payment
- Health Care Operations
- Notifications
- Marketing Research
- Special circumstance & the law

Please understand that this summary is not our Notice of Privacy Policies, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number above to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining this signed acknowledgment. If, after reviewing the notice, you decide that you do not want to retain your copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices and the office policies & procedures and do with to receive treatment:

Signature _____ Printed Name _____ Date _____

Margaret Leila Rasouli, M.D., Inc.
DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE,
CARDIOVASCULAR DISEASE, INTERVENTIONAL
CARDIOLOGY AND NUCLEAR CARDIOLOGY

CANCELLATION AND NO SHOW POLICY

Our goal is to provide quality individualized medical care. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. As of **April 1, 2016**, we have enforced cancellation/missed/no show fees. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellations

We know that your time is valuable and that there may be special unavoidable circumstances that may cause you to cancel, however in order to be respectful of the medical needs of other patients, please be courteous and call our office promptly at 949 600-7228 to cancel your appointment.

Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change or cancel an appointment, please notify us **no less than 24-hours (1 business days).*** For example, if the appointment is on Wednesday at 2 p.m., it must be cancelled no later than Tuesday at 2 p.m.* This courtesy makes it possible to give your reserved time to another patient who is in need of our care.

Missed/No Show Appointments

We understand that occasional missed appointments can occur for a variety of reasons. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling, **24-hours (1 business days)** before your scheduled time.

Cancellation/Missed/No Show Appointment Fee

Office appointments which are cancelled with less than 24 business hours will be subject to a fifty dollar (**$50.00**) cancellation fee. *Diagnostic appointments* (i.e. Echocardiogram, Stress Test) with notice of less than 24 business hours will be subject to a fifty dollar (**$50.00**) cancellation fee.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication

Thank you.

_____ _____

Signature Date