PARGOL SAMANI, M.D., INC.
3927 Waring Rd, Suite C, Oceanside, CA 92056

PATIENT REGISTRATION FORM

Patient Information:

First Name:	Last Name:
Sex: ☐Male ☐Female	Date of Birth:
SSN:	Occupation:
Address: City:	State: Zip Code:
Mobile Phone: Home Phone:	Email: Work Phone:
Primary Care Doctor:	Referred By:
Pharmacy Name/Address:	Lab Name/Address:
Emergency Contact Name:	Emergency Contact Phone:
Guardian First Name:	Guardian Last Name:

Insurance Information:

Primary Insurance:	Secondary Insurance:
Insured's Name (if different from patient):	Insured's SSN (if different from patient):
Insured's Address (if different from patient):	Insured's Phone Number (if different from patient):

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Pargol Samani M.D. Inc. I understand that I am financially responsible for any balance. I also authorize Pargol Samani M.D. Inc. or insurance company to release any information required to process my claims. I also acknowledge receipt of the Notice of privacy practice.

Patient/Guardian signature

Date

PARGOL SAMANI, M.D., INC.

3927 WARING RD, SUITE C, OCEANSIDE, CA 92056
TEL: (619) 703-7220 FAX: (619) 703-7221

Patient Name: _____

Heart Disease History		If yes, please describe
History of heart attack	□ Yes	
History of angioplasty, stents or bypass surgery	□ Yes	
History of valve replacement, TAVR	□ Yes	
Pacemaker of defibrillator	□ Yes	
Heart failure now or previously	□ Yes	
High blood pressure	□ Yes	
High cholesterol	□ Yes	
Diabetes or borderline diabetes	□ Yes	
Overweight/Obesity	□ Yes	
Have you been told you have a “heart murmur”	□ Yes	
Have you been told you have a “ leaky heart valve”	□ Yes	
History of stroke or “mini-stroke” or TIA	□ Yes	
History of blood clot (in legs or lungs)	□ Yes	
History of atrial fibrillation or electric shock	□ Yes	
History of irregular heartbeats or arrhythmia	□ Yes	
Aneurysm/enlargement of aorta	□ Yes	
Kidney disease	□ Yes	
Have you ever had any cardiovascular work up in the past (like ultrasound of the heart or stress test or heart monitor)	□ Yes	

Symptoms		If yes, please describe
Chest pain, tightness or pressure or discomfort	□ Yes	
Jaw, arm, or shoulder pain	□ Yes	
Shortness of breath at rest	□ Yes	
Shortness of breath with walking, going upstairs	□ Yes	
Waking up with shortness of breath at night	□ Yes	
Palpitation or rapid heartbeats	□ Yes	
Skipped heart beats	□ Yes	
Irregular heartbeats, fluttering	□ Yes	
Slow heart rate, Heart stopping	□ Yes	
Dizziness or lightheadedness	□ Yes	
Near fainting or fainting or syncope now or in the past	□ Yes	
Fatigue	□ Yes	
Calf pain or cramps at rest or with walking	□ Yes	
Buttock or tight pain with walking	□ Yes	
Swelling (puffiness) in the legs or feet or ankles	□ Yes	
Weakness or numbness or paralysis	□ Yes	
Vision change, double or blurry vision	□ Yes	
Difficulty finding words or slurry speech or confusion	□ Yes	
Difficulty with balance	□ Yes	
Unusual weight loss of weight gain	□ Yes	
Fever, chills or night sweats	□ Yes	
Snoring	□ Yes	
Feeling tired and not fully rested in the morning	□ Yes	

Medications	Dose (mg)	How Often (once a day, etc…)
1-		
2-		
3-		
4-		
5-		
6-		
7-		
8-		

Allergies to Medication or Food	□ Yes	If yes, please describe
Penicillin	□ Yes	
Shell Fish	□ Yes	
Other	□ Yes	

Prior Medical Condition or Surgery	□ Yes	If yes, please describe
1-		
2-		
3-		
4-		

Health and Fitness		If yes, please describe
Do you smoke or vape or use any nicotine related products?	□ Yes	If yes, how much?
Did you smoke in the past?	□ Yes	What type and how much?
Do you exercise?	□ Yes	What type and how much?
Do you drink alcoholic beverages?	□ Yes	What type and how much per day?
Do you drink caffeinated beverages?	□ Yes	How much per day?
Do you work?	□ Yes	Do you do physical work?
Do you eat healthy?	□ Yes	What are the weaknesses in your diet?

Family Histories		If yes, please describe
Any family member with heart issue in your family?	□ Yes	
Any family member with heart attack before age 65?	□ Yes	
Any family member with sudden cardiac death?	□ Yes	
Any family member with high blood pressure?	□ Yes	
Any family member with high cholesterol?	□ Yes	
Any family member with diabetes?	□ Yes	
Any family member with arrhythmia or atrial fibrillation	□ Yes	
Any family member with enlarged aorta?	□ Yes	

What are the heart and/or blood circulation related concerns that you would like to discuss with the doctor?

Pargol Samani MD, INC.

3927 Waring Rd, Suite, Oceanside, CA 92056 Phone: (619) 703-7220 Fax (619) 703-7221

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: ---------- Date of birth: ----------
Phone number: ---------- Social Security number: ----------

I hereby request and authorize ---------- to release healthcare information of the patient named above to:

Pargol Samani MD, Inc
3927 Waring Rd, Suite C, Oceanside, CA 92056
Phone: (619) 703-7220 | Fax: (619) 703-7221

The request and authorization applies to:
✓All health information pertaining to my medical history or physical condition and treatment receive, including:
✓History and Physical Reports ✓EKG ✓ Echocardiogram ✓Carotid Ultrasound ✓Aortic Ultrasound
✓Lower extremities Ultrasound ✓Renal Ultrasound ✓Stress Test ✓Procedure Report
✓Radiology Report ✓Discharge Summaries ✓Emergency Department Reports ✓Laboratory Reports
✓All healthcare information on record
✓Other: ----------

Purpose of requested use or disclosure is Patient request; OR Other: ----------

I understand and acknowledge that these records may include mental health treatment information, HIV test results and alcohol/drug treatment information. A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.1 This authorization expires 90 days after it signed.

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Pargol Samani, MD, Inc, 3231 Waring Ct, Suite P, Oceanside, CA 92056.
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE (patient/legal representative) Date: ----------

If signed by a person other than the patient, indicate relationship: ----------

Print name: (legal representative) ----------

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

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for this health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate needed medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to determine a diagnosis or treatment or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services received from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order to obtain payment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members providing this care. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of an armed forces family, we may disclose Protected Health Information as required by military command authorities.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you or your family members are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

<u>Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out</u>

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes or evaluations by psychologists;
  Uses and disclosures of Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information.
- Any information related to diagnosis or treatment of HIV, Alcohol and Substance Abuse information, Mental Health Information or Genetic Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for this care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with this request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

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Acknowledgements of Receipt of Notice of Privacy Practice

I herby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practice. I further acknowledge that a copy of the current notice will be posted in a reception area, and that I will be offered a copy of any amended Notice of Privacy Practice at each appointment. In addition, I give permission to have my medication and allergy history obtained from pharmacies electronically by Pargol Samani M.D., Inc.

☐ Patient
☐ Parent or guardian of minor patient
☐ Guardian or conservator of incompetent patient

Print Name: _____ Phone: _____

Signature: _____ Date: _____

If not signed by the patient, please enter:
Name and Address of the Patient: _____

Disclaimer: This document and the information in it do not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPPA regulations.

I wish to be contacted by Pargol Samani M.D., Inc. in the following manner (check all that apply):

☐ Cellphone: _____
☐ Home Telephone: _____
☐ Work telephone: _____

☐ Leave voice message
☐ Leave message with callback number only
☐ Fax to this number
☐ Give health information to the following family member(s): _____

Patient Signature: _____ Date: _____