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Dear Patient,

WELCOME to Contra Costa Cardiology Medical Group! Our physicians and staff look forward to caring for and meeting your cardiac care needs.

Please fill out the enclosed forms and have them available upon check-in when you arrive to your appointment.

Along with these forms, please remember to bring with you to your appointment the following:

1. Your Medical Insurance card(s). (Primary and Secondary insurances if applicable)
2. Your Insurance Referral from your Primary Care Provider. (HMO insurances only)
3. Copayments must be paid at the time of visit. (we gladly accept cash, checks, Visa, MC, American Express and Discover)

**Please note, with out insurance information, patients will be responsible for payment at the time of service.**

All Non-Invasive Testing appointments (Echocardiograms, Stress Echos and Nuc Med Studies) require a 24 hour cancellation notice or you will be charged a \$50.00 cancellation fee plus any applicable medication charges. These charges are typically not paid by the insurance carriers.

Please be aware that it is your responsibility to contact your primary care physician to obtain a referral authorization to see a Contra Costa Cardiology physician. If you are not sure if your insurance company requires an authorization, please contact your insurance company or employer's benefit office.

If your insurance plan does require a referral for your office visit but you still choose to see a physician in our group without a referral, you will still be seen by one of our doctors. However you will be billed for the visit. If you are uncertain about the status of your present referral, please feel free to call our office to see if a new referral is needed for your pending visit.

We understand that the insurance process can be confusing and difficult to navigate. If you have questions regarding this policy, please call us. For questions related to your specific coverage or benefits, please contact your insurance carrier.

Below are some steps that might be helpful in knowing which insurance requires referrals and/or authorizations

INSURANCE	INFORMATION NEEDED	
Hill Physicians Medical Group	Referral	Good for one year from issue date
John Muir Health Network	Referral	One time referral per primary care MD
CCHP – All Plans	Referral	Good for two visits (commercial plans 6 months)
	Authorization	Required for all tests and/or procedures

Sincerely,

The physicians and staff of  
Contra Costa Cardiology Medical Group

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ If retired, give date: \_\_\_\_\_

Single Married Divorced Widowed Referring Physician: \_\_\_\_\_

Allergies to food or medication: \_\_\_\_\_

**Present Illness: Please circle the following symptoms you have now or have had in the past:**

- |   |   |
|---|---|
| 1. Pain, pressure or any discomfort in the chest.           | 11. Easily Fatigued.                      |
| 2. Rapid or irregular heart beats (palpitations).           | 12. Urinating at night.                   |
| 3. Shortness of breath at rest.                             | 13. Abnormal electrocardiogram (EKG).     |
| 4. Shortness of breath with effort.                         | 14. Blood in urine or stools.             |
| 5. Cough.   | 15. Constipation and/or diarrhea.         |
| 6. Coughing up blood.                                       | 16. Decreased sexual function.            |
| 7. Weight gain of more than 5-10 lbs. In the last 3 months. | 17. Frequent feelings of nervousness.     |
| 8. Swelling of the ankles.                                  | 18. Trouble getting a good night's sleep. |
| 9. Passing out.   | 19. Feelings of severe depression.        |
| 10. Dizzy spells.   |   |

**Rank the health problems you want addressed in their order of priority:**

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Please list all your current prescription medications, over the counter medications, and vitamins, with their dosage and how many taken each day:**

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**Please indicate if you have had the following tests and give approximate dates:**

- |                                  |                                  |
|----------------------------------|----------------------------------|
| 1. Electrocardiogram (EKG) _____ | 4. Exercise stress test _____    |
| 2. Echocardiogram _____          | 5. Cardiac Catheterization _____ |
| 3. Chest Xray _____              | 6. 24-hour Holter _____          |

**If you have had any of the following conditions please write the approximate date:**

- |                               |                                      |                           |
|-------------------------------|--------------------------------------|---------------------------|
| 1. Heart Murmur _____         | 5. Lung Disease _____                | 9. Kidney Disease _____   |
| 2. Heart disease _____        | 6. Cramps in legs with walking _____ | 10. Thyroid trouble _____ |
| 3. Elevated cholesterol _____ | 7. Cramps in legs at night _____     | 11. Stroke _____          |
| 4. Diabetes _____             | 8. High Blood pressure _____         | 12. Rheumatic fever _____ |

**History of smoking,** \_\_\_\_\_ packs per day \_\_\_\_\_ year started \_\_\_\_\_ year stopped

History of previous illness (list those not previously mentioned under present illness and give dates): \_\_\_\_\_

Operations: Name operation and give dates: \_\_\_\_\_

Pregnancies: Give date of delivery and birthweight (note any complications): \_\_\_\_\_

**Family History: Below is a list of diseases which tend to run in families. If any of your close relatives or children have any of these please fill in the box with date of onset:**

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease						
High blood pressure						
Stroke						
Cancer						
High cholesterol						
Diabetes						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental illness						
Epilepsy/Convulsions						

Do you use the following:	Yes	No	Year Started	How Much
Coffee				
Sleeping pills/Tranquilizers				
Alcohol				
Recreational drugs				

Do you exercise apart from your work?      Yes      No

Type of exercise \_\_\_\_\_ How often? \_\_\_\_\_

Thank you for your time and cooperation in filling out this form. It will be kept in this office and remain a confidential record of your medical chart.



# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Contra Costa Cardiology Medical Group  
2485 High School Avenue Ste. 100  
Concord, CA 94520

I understand that, under the Health Insurance Portability and Accountability act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment either directly or indirectly
- Obtain payment from my insurance company or other agency responsible for the payment of my medical care.
- Conduct normal health-care operations such as quality improvement and physician certification.
- Notify me of upcoming appointments and leave return medical messages on my answering machine.

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain the current copy of the notice of privacy practices

I understand that I may request in writing that you restrict, how my private information is used or disclosed to carry out treatment, payment or health-care operations. I understand you are not required to agree to my requested restrictions but if you do then you are required to abide by such restrictions.

Patient Name \_\_\_\_\_

Relation to Patient (self) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Others to whom the practice may release information \_\_\_\_\_  
Name Relation

If you need additional contacts please list on back of sheet

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason