windwardheart
center LLC

Patient Registration Pack

Contents

Welcome to Windward Heart Center LLC.

At Windward Heart we strive to give our patients timely access to care. The forms included in this pack will help to expedite your registration with our practice.

Please bring these forms, completed, along with your insurance cards and photo ID to your appointment.

If you do not yet have an appointment with us, please call (808) 261 2441 to schedule.

Sonny J.H. Wong MD FACC
Maria Markarian DO FACC
25 Maluniu Ave
Suite #201
Kailua, Hawaii 96734

ph (808) 261 2441
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www.windwardheart.com

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Patient Registration Form

Referring or Primary Care Physician

Patient Name

Date of Birth Gender ☐ Female ☐ Male

SSN# Drivers License #

Address

Email

Home Phone Cell Phone

Work Phone How would you like to be reached?

Billing Address (if different from above)

Guarantor Name (if different from above)

Address

Language

Ethnicity ☐ Non-Hispanic ☐ Hispanic

Race ☐ Asian ☐ White ☐ African American ☐ Hawaiian ☐ Pacific Islander ☐ Other

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed

Employment Status ☐ FT ☐ PT ☐ Retired ☐ Active Duty ☐ Self Employed

☐ Not Employed ☐ Student

Name of Employer or School

Work Phone

This visit is related to work injury or no fault automobile injury? ☐ Yes ☐ No

Date of Injury

Do you have an Advanced HealthCare Directive*? ☐ Yes ☐ No

Spouse or Next of Kin

Relationship Phone

* Advanced HealthCare Directives are specific instructions, prepared in advance, intended to direct a person's medical care in the event that he/she is unable to do so in the future.

Insurance

Primary Insurance Name

Subscriber ID # | Date of Birth

Subscriber Name | Relation to Patient

Secondary Insurance Name

Subscriber ID # | Date of Birth

Subscriber Name | Relation to Patient

Third Insurance Name

Subscriber ID # | Date of Birth

Subscriber Name | Relation to Patient

I authorize the release of confidential medical information to the following contact persons

Name | Name

Relationship | Relationship

Phone | Phone

Emergency Contact

Name

Relation to Patient

Phone

Authorization for treatment, release of information, assignment of benefits and acknowledgement of responsibility for payment for physician services.

I hereby give my consent to Windward Heart Center LLC, Sonny J.H. Wong, M.D., F.A.C.C. and Maria Markarian, D.O., F.A.C.C, to provide whatever treatment is deemed necessary.

I authorize any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these and related services.

I request that payment of authorized Medicare and other insurance benefits be made to me or on my behalf to Windward Heart Center LLC, Sonny J.H. Wong, M.D., F.A.C.C. and Maria Markarian, D.O., F.A.C.C, for any services furnished. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges incurred, including any no show or late cancellation fees, and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection cost, in the event my account becomes delinquent.

Signature

Relationship to patient (if other than self)

Date

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Patient Partnership Agreement

Thank you for choosing Windward Heart and Vein Center for your health care needs. This document details what we ask of you as we enter into a partnership to provide your medical care. If you have any questions, please don't hesitate to ask.

Please pay charges at time of service

Charges include co-payments, co-insurance payments, and deductibles as well as any charges for services that are not covered by your health insurance plan.

For patients with health insurance plans, we file a claim to your primary insurance carrier to receive payment for your visit. Please note, if your health insurance plan does not provide reimbursement of the claim within 60 days after your appointment the unpaid balance will become your responsibility.

Appointments and cancellations

Windward Heart and Vein Center staff will contact and remind you one to two days before your scheduled appointment.

Please arrive15 minutes before your appointment time is scheduled for the check-in process. We strive to ensure that your appointment begins at the time that it is scheduled, and the check in process occurs prior to your appointment.

If you are unable to make your appointment, we would like to know as soon as poosible so we can allow another patient to receive care during that time. Please call us at least 24 hours before a consultation or 48 hours before a procedure if you need to cancel or reschedule your appointment.

If you miss your appointment, or do not call to cancel or reschedule within the requested time before your appointment, we request a missed appointment fee of the following:

Procedures 48 hour cancellation time

Holters	$75
Event Monitors	$75
Echocardiograms	$75
Nuclear Stress Tests	$200
Spider Vein Scleropathy or Laser	$75
Endovascular Ablation	$200
Laser Hair Removal or Botox	$25

Consultations 24 hour cancellation time

Follow Up	$25
Pace Maker Check	$25

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Of course, we understand that sometimes the unexpected does occur and results in a missed appointment. In order to continue to provide the level of care that we do, we rely upon you to assume the responsbility of such instances and reimburse us for the time that was alloted for your care.

All federal or state funded insurance participants, such as the Quest program, will be asked to find a different physician if we experience 2 no shows or late cancellations under 24 hour notice per calendar year.

Non-covered benefits

Occasionally patients may request certain professional services that may not be covered by health insurance plans. A fee may be assessed for such services.

Examples include:
- Patient requested written correspondence
- Copying/printing medical records
- Other fax services

Returned checks

We request a $25 service fee on all returned checks.

Delinquent accounts

Accounts past due will be placed on a cash only status, at which time all balances due must be paid in full at each visit.

I have read and understand this document and agree to abide by its terms. All of my questions regarding this document have been explained to me.

I understand that charges not covered by my health insurance plan, or not paid to Windward Heart Center LLC, Sonny J.H. Wong, M.D., F.A.C.C. and Maria Markarian, D.O.,F.A.C.C, within 60 days of the service rendered, as well as any applicable fees, co-payments, and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Windward Heart Center LLC, Sonny J.H. Wong, M.D., F.A.C.C. and Maria Markarian, D.O.,F.A.C.C. I authorize Windward Heart Center to release pertinent medical information to my insurance company when requested to facilitate payment of a claim.

Patient Name - Please print

Patient Signature Date

Office Staff Signature Date

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of the office that are involved in your care, for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of you healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for you health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as-needed, your protected health information in order to support our practice’s activities, training of medical students, and licensing. For example, we may disclose your protected health information to medical school students that see patients at our office. In our day to day practice activities, we may use a sign-in sheet at the registration desk , we may also call you by name in the waiting room when your physician is ready to see you. Your protected health information may also be used to contact you to remind you of an appointment.

Disclosures Not Requiring Your Permission

Windward Heart Center may make disclosures of your protected health information to or regarding the following when required by law.

Public Health

Health Oversight Activities

Judicial and Administrative Hearings

Law Enforcment purposes

Coroners, Medical Examiners, and Funeral Directors

Organ Donation and Disease Registries

Research Purposes

Correctional Institutions

Workers' Compensation

Your Rights to Privacy

Your medical information will not be shared and/or disclosed to anyone without your permission except as described in this notice or required by law. You may, in writing, revoke this authorization at any time. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to inspect and copy your protected health information

If you request a copy of the information we may charge a reasonable fee for the cost of copying, mailing or other supplies associated with your request. Under federal law, however, you may not inspect or copy psychothearapy notes; information completed in reasonable anticipation of, or use in a civil criminal, or administrated action or proceeding, and protected health information that is subject to law that prohibits health information. You also have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information, as well as extra copies of this notice.

You have the right to request a restriction or an amendment of your protected health information

This means that you ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Please note, your physician is not required to agree to a restriction or amendment that you may request if they believe it is in your best interest. You then have the right to use another healthcare professional or file statement of disagreement with us.

Complaints

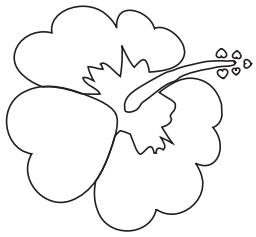
You may complain to us or to the Secretary of Health and Human Services if you have concerns about your privacy.
We will not retaliate against you for filing a complaint.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. This notice became effective April 14, 2003.

Print Name _____

Signature _____ Date _____

Signature is only acknowledgement that you have received this notice of our Privacy Practices.



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Pharmacy Information and Policy

Preferred Pharmacy _____

If you prefer to use an **off island** pharmacy please provide the telephone and fax number

Pharmacy Name _____

Telephone _____

Fax _____

Dr Wong and Dr Markarian prefer that their patients use local pharmacies. Not only does this support on island businesses, but it also provides them with the ability to ensure that prescriptions reach the pharmacy correctly and in a timely manner. In the instance that a discrepancy occurs, on island pharmacies allow for Dr. Wong or Dr. Markarian to resolve issues as soon as they arise.

Should you choose to use an off island pharmacy, Windward Heart Center LLC is not responsible for any problems that may arise in doing so, e.g. loss of prescription, length of time for prescription to be filled.

Please be sure to advise the nurse and doctor when you will need a refill, as it will only be dispensed to only one pharmacy.

I have read and understand the Pharmacy Policy.

_____

Signature

_____

Date

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