Beverly Hills
Institute for Cardiology & Preventative Medicine
by Dr. Arash Bereliani

Thank you for choosing Dr. Arash Bereliani. Our office looks forward to serving you.

PRIOR TO YOUR APPOINTMENT

EMAIL OR FAX:

To expedite the check-in process and verify insurance eligibility please return the following 48 hours prior to your scheduled appointment.

1. Attached New Patient Paperwork.
2. A color copy of a government issued identification card
3. A color copy of the front and back of each insurance policy you have.

Please email to: Reception@BerelianiMD.com or fax to: 855.266.3948

APPOINTMENT:

You will receive a confirmation phone call the day before your appointment reminding you of your appointment time. If for any reason you are unable to keep your confirmed appointment, please call our office 24-hours prior to your appointment to reschedule your visit to better fit your needs and avoid the cancellation fee.

CONTACT INFORMATION:

Note our telephone hours are 9:00 am to 5:00 pm M – F. Please call us at (310) 550-8000, #1. One of our staff members will be happy to assist you.

THE DAY OF YOUR APPOINTMENT:

DIRECTIONS:

Our address is: 125 N. Robertson Blvd, Beverly Hills, CA 90211. When entering the address into a GPS device, be sure you are being navigated to the city of Beverly Hills - **NOT Los Angeles** as they are two different addresses and are very close in proximity. We are in a street level brick building. Planet Pharmacy is our neighboring business and is on the street front of the courtyard.

PARKING:

We have limited parking available to our patients at no charge. Our available parking spaces are easily accessible from the parking lot located to the right-hand side of the building (if you are facing the building) on Robertson. Our dedicated spaces are numbered 1 -3. In addition, we have 4 parking lot spaces behind our building in the alley way. To access the parking spaces in the alley way, drive through the parking lot and make a left turn in to the alley way, you will see the spaces for Dr. Bereliani on your left-hand side. Otherwise, there is a parking structure available across the street on Robertson or you are more than welcome to park at any of the meters on Robertson or side streets.

ARRIVE 15 MINUTES EARLY:

There are additional steps to the registration process that must be competed at the office on your first visit. Please arrive 15 minutes early. Please be prepared to satisfy the co-payment required by your insurance company or the balance of any unmet deductible.

Thank you again for trusting Dr. Arash Bereliani with your healthcare needs.

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125 N. Robertson Blvd, Beverly Hills, CA 90211
o: 310.550.8000 | f: 310.652.5763
www.BerelianiMD.com

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ (Last / First / Middle)

Date of Birth: _____ Sex: _____ Martial Status: _____

Mailing Address: _____ (Address / City / State / Zip)

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____ Send appointment reminders to: _____

Are you a cardiology patient? _____ Have you ever seen a cardiologist?: _____

If you have seen a cardiologist, who? _____

Who is your primary physician: _____

How were you referred to us? _____

EMERGENCY CONTACT

If patient is a child, please provide an emergency contact other than a parent/guardian.

Contact Name: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

PRIMARY RESPONSIBLE PARTY

Responsible Party: _____

Full Name: _____ (Last / First / Middle)

Date of Birth: _____ Sex: _____ Phone: _____

Address: _____ (Address / City / State / Zip)

INSURANCE INFORMATION

Primary Insurance Provider: _____

Subscriber's Name: _____ Date of Birth _____ Relationship: _____

Insurance Address: _____

Secondary Insurance Provider: _____

Subscriber's Name: _____ Date of Birth _____ Relationship _____

Insurance Address: _____

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Patient Full Name:

FINANCIAL RESPONSIBILITY

I hereby certify that I am eligible with the health insurance company under the subscriber indicated on my registration sheet. I directly assign all medical benefits available through my health insurance coverage to Arash Bereliani M.D. for services rendered. I understand the practice is heavily geared towards prevention. This means looking for "markers" which indicate a statistical probability that certain disease states will develop. These "markers" can be genetic, biochemical, nutritional or other detectable features. I understand the likelihood of treating a disease is to identify them before symptoms are present. I understand that my care may involve extensive testing and treatments that may be beneficial to me. Often, insurance companies do not pay for preventive care; including laboratory costs and professional fees of the physician. I understand it is my responsibility to raise any questions regarding the type of treatment I am receiving and to understand the costs before treatment and testing are initiated. I understand, that I am financially responsible for all charges whether paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature: **Date:**

COMMUNICATION CONSENT

By providing Dr. Arash Bereliani and the Beverly Hills Institute for Cardiology & Preventive Medicine or its service providers with a telephone number for a cellular or other wireless device and/or an e-mail, I agree that they may use the provided telephone number or e-mail to service my account(s) (including contacting me about obtaining potential financial assistance for my account(s)), to send the patient appointment and follow-up health care reminders by text or e-mail, to send me information, to schedule patient appointments, and to collect any amounts I may owe to my healthcare provider(s). I understand and agree that Dr. Arash Bereliani and the Beverly Hills Institute for Cardiology & Preventive Medicine and its agents, representatives, or other service providers as well their respective agents and contractors, including any billing or account management companies and/or debt collectors may contact me at the provided telephone number(s) which could result in charges to me. I expressly consent that methods of contact may include using pre-recorded and artificial voice messages, text, email, (if an email address has been provided) and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with my account number(s) and is not a condition of purchasing property, goods, or services. I am not required to sign this consent as a condition of receiving healthcare services.

Signature: **Date:**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me, or on my behalf, to Arash Bereliani M.D., or any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown in Medicare assigned cases. The physician or suppliers agree to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

☐ I DO NOT HAVE MEDICARE DOES NOT APPLY ☐ I DO HAVE MEDICARE AND AUTHORIZE

Signature: **Date:**

CANCELLATION POLICY

I request that payment of authorized Medicare benefits be made to me, or on my behalf, to Arash Bereliani M.D., or any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown in Medicare assigned cases. The physician or suppliers agree to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. To be consistent with this philosophy, our office uses an appointment system that sets aside ample time for each patient dependent on the patient's medical needs. If you do not show up for your appointment or notify us of your inability to keep your appointment, the time allotted for your visit cannot be used to treat another patient. We request 24-hour notice to reschedule your appointment or a no-show fee will be charged. If you miss a new patient appointment, your credit card that is on file will be charged $350. If you miss a follow-up appointment, your credit card that is on file will be charged $75. As an extended courtesy, our office makes a reminder call the day before an appointment. If you do not receive your reminder call or message, the cancellation policy will remain in effect. The credit on your credit card authorization form will be used to automatically charge for a missed appointment.

Signature: **Date:**

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Patient Full Name:

CREDIT CARD AUTHORIZATION FORM

CARDHOLDER INFORMATION

Name:

Billing Street Address:

Street Address (cont.):

City: State: Postal Code:

Country:

Direct Telephone:

CREDIT CARD INFORMATION

Credit Card Type:

Card Number:

Expiration Month: Expiration Year:

Security Code:

I authorize the Office of Arash Bereliani M.D.,to keep my credit card on file and to charge my credit card for cancellation fees and open invoices.

Signature:

Date:

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MEDICAL HISTORY

Check any conditions you currently are being treated or have been treated for in the past

- ☐ Heart Disease/ Murmur
- ☐ Chest Pain/ Angina
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Sleep Apnea
- ☐ Heartburn (Reflux)
- ☐ Anemia
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Lung Problems
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Tonsillitis
- ☐ Ear Problems
- ☐ Prostate Disease
- ☐ Eye Disorder
- ☐ Kidney/Bladder Issue
- ☐ Liver/Hepatitis Issue
- ☐ Headaches/Migraines
- ☐ Neurological Issue
- ☐ Depression/Anxiety
- ☐ Psychiatric Care
- ☐ Swollen Ankles
- ☐ Diabetes
- ☐ Seizures
- ☐ Stroke
- ☐ Arthritis
- ☐ Cancer
- ☐ Ulcers/Colitis
- ☐ Thyroid Problems

Please describe any current or past medical treatment not listed above

Please list your past surgeries

Social and Preventative History

Do you use tobacco? ☐ How many packs per day? ☐

Do you drink alcohol? ☐ How many drinks per day? ☐

Family History

	Brother/ Sister	Deceased Y/N	Age Current or at death	Major Health Problems
Mother		☐		
Father		☐		
Sibling 1	N/A	☐		
Sibling 2	N/A	☐		
Sibling	N/A	☐		
Sibling 4	N/A	☐		

Do you have any known allergies? If so, please list below: ☐ **Yes** ☐ **No**

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MEDICATION LIST

Medications: Prescriptions, non-prescription medicines, vitamins, home remedies, birthcontrol pills, herbs.

Medication	Dose	Times per day

HEALTH MAINTENANCE SCREENING TESTS:

Sigmoidoscopy Date: ☐ Abnormal: ☐ Yes ☐ No

Colonoscopy Date: ☐ Abnormal: ☐ Yes ☐ No

Women:

Mammogram Date: ☐ Abnormal: ☐ Yes ☐ No

Dexa Scan (osteoporosis) Date: ☐ Abnormal: ☐ Yes ☐ No

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CARDIOLOGY PATIENT - SYMPTOMS

IF YOU ARE A CARDIOLOGY PATIENT, PLEASE COMPLETE THE NEXT TWO PAGES:

1. CHEST PAIN / DISCOMFORT:

Have you had any pain or discomfort above your waist in the last 12 months? ☐ No ☐ Yes

If YES:

a. Approximately how long have you had this pain or discomfort? _____

b. Does the pain/discomfort occur mostly in the center of your chest? ☐ No ☐ Yes
If not, which of the following locations describe most of your discomfort?
☐ Left side of the chest ☐ Left arm ☐ Neck or Jaw Other: _____

c. Does the pain/discomfort occur commonly with physical exertion? ☐ No ☐ Yes

If Yes, does the pain/discomfort go away within 10 minutes with rest? ☐ No ☐ Yes

d. Does the pain/discomfort go away with nitroglycerin? ☐ Never Taken ☐ No ☐ Yes

e. Has this pain or discomfort been getting worse during the last month?
(i.e. more often, more severe or intense, or lasting longer) ☐ No ☐ Yes

2. SHORTNESS OF BREATH:

a. Have you had any shortness of breath in the last 12 months? ☐ No ☐ Yes

b. Do you have shortness of breath during physical exertion? ☐ No ☐ Yes

c. Have you had worsening shortness of breath during the last month?(i.e. more often, more severe or intense, or lasting longer) ☐ No ☐ Yes

3. OTHER SYMPTOMS:

a. Have you had any of the following in the last 12 months?

i. Palpitations ☐ No ☐ Yes

ii. Fainting, syncope (blackouts) ☐ No ☐ Yes

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CARDIOLOGY PATIENT - HISTORY

1. Have you ever had the following?

b. HEART ATTACK (myocardial infarction)? ☐ No ☐ Yes
   i. Date of most recent [MM-DD-YY]:
   ii. Location [Hospital, City, State]:

c. CARDIAC CATHETERIZATION for a coronary angiogram? ☐ No ☐ Yes
   i. Date of most recent [MM-DD-YY]:
   ii. Location [Hospital, City, State]:

d. CORONARY ANGIOPLASTY (balloon or stent)? ☐ No ☐ Yes
   i. Date of most recent [MM-DD-YY]:
   ii. Location [Hospital, City, State]:

e. CONGENITAL HEART DISEASE ☐ No ☐ Yes
   (problems with your heart chamber/valves, "holes" or "murmur" in the heart?)
   Describe type of congenital heart disease:

f. HEART SURGERY? ☐ No ☐ Yes
   i. Date of most recent [MM-DD-YY]:
   ii. Location [Hospital, City, State]:
   iii. What type of heart surgery did you have? Mark all that apply.
   ☐ Bypass Surgery ☐ Valve Surgery ☐ Heart Transplant ☐ Other:
   ☐ Congenital *(Describe repair)*:

f. Pacemaker? ☐ No ☐ Yes

g. Defibrillator *(ICD)*? ☐ No ☐ Yes

h. Coronary Calcium Scan? *If yes, Score:* ☐ No ☐ Yes

i. Have you ever been told by a health care practitioner that you have: Mark all that apply
   ☐ A heart valve problem ☐ A heart murmur ☐ Irregular heartbeat *(arrhythmia)*
   ☐ Atrial flutter or fibrillation? ☐ Heart failure ☐ Stroke or TIA *(transient ischemic attack)*
   ☐ Renal *(kidney)* failure or dysfunction

j. Do you experience cramping in your calves when you walk? ☐ No ☐ Yes

k. Has anyone in your family had heart related issues. If so who and what: ☐ No ☐ Yes

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CARDIOLOGY PATIENT - CONCERNS

When it comes to your heart health, please tell us your main concerns and anything that you would like for Dr. Bereliani to know.

Would you be interested in information for advanced preventative heart testing, that may not be covered by your insurance? **No** ☐ **Yes** ☐

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Phone: (310) 550-8000 Fax: (310) 652-5763

Release of Healthcare Information

I, _____ understand my medical records (including but not limited to insurance information, demographics, consult notes, lab/imaging results), may be sent to other treating healthcare provider upon request. My medical records may also be sent to potential healthcare providers requesting healthcare information in order to schedule me for an appointment. This will solely be done for coordination of my medical care to reduce unnecessary testing and an overall better, swifter, and thorough treatment of my medical support.

_____ _____

(Patient's Full Name) (Please Print) (Patient Signature)

_____ _____

(Date) (Signature of Representative, If other than patient)

Beverly Hills Institute for Cardiology
And Preventative Medicine

Patient Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Beverly Hills Institute for Cardiology and Preventative Medicine, under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice* and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

FOR MEDICARE PATIENTS ONLY

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospital be made available to the public.

You may search this federal database for payments made to physicians and teaching hospitals by visiting this website:

http://openpaymentsdata.cms.gov/

Patients signature_____

Date_____