PCP

EAST BAY CARDIOVASCULAR & MEDICAL SPECIALISTS

Name of doctor you are seeing today_____Date: _____

PRINT CLEARLY All questions must be answered.

Name_____ DOB:___/____/___ Gender:_____

Address_____

Home: (___)_____Cell: (__)_____Work: (___)_____

Email:_____

Married: Yes / ***No (Spouse Name:***_____ Cell:_____)

Emergency Contact:

Name:_____

Tel#:(___)_____Relationship to patient:_____

Primary Insurance

Name:_____ID#:_____

Secondary Insurance

Name:_____ID#:_____

Guarantor: Name:_____DOB:____/_____/_____

Preferred Language?_____Interpreter Needed? □ Yes □ No
ASL Interpreter? □ Yes □ No (if hearing impaired)

Primary Care Physician

Name:_____

Referring Physician

Name:_____

Do you have an Advanced Healthcare Directive [ ] Yes [ ] No (if yes, please provide copy)

Do you have a Durable Power of Attorney [ ] Yes [ ] No (if yes, please provide copy)

EAST BAY
CARDIOVASCULAR
& MEDICAL SPECIALTY

Patient Financial Responsibility Acknowledgment
East Bay Cardiovascular and Medical Specialty

Date:
Patient Name:
Procedure:

Dear ,

Your insurance provider may not cover the above procedure, or it is considered non-covered, investigational, or not medically necessary under your insurance plan. As such, you may be financially responsible for the full cost of this service.

By signing below, you acknowledge and agree to the following:

1. Insurance Denial: You understand that your insurance may not pay for this procedure, and that you are responsible for payment if it is denied.
2. Estimated Cost: The estimated cost for the procedure is $. This is an estimate and subject to change depending on additional services rendered.
3. Payment Responsibility: You agree to pay the full amount for the procedure if insurance does not cover it, in accordance with the practice's billing policies.
4. Appeal Rights: You understand that you may request your insurance provider to review or appeal any denial of coverage, but this does not delay or relieve your responsibility for payment.

Please sign below to indicate your understanding and acceptance of financial responsibility.

Patient Signature: _____

Date: _____

Witness (EBCMS Staff): _____

Date:_____

HIPAA ACKNOWLEDGEMENT

Please initial that you have read:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You have the right to revoke this consent at any time by giving this office written notice of your revocation. Please understand that we could no longer file insurance claims for you and that it will not affect any action we took in reliance on this consent prior to receiving your revocation and that we may decline to treat or continue treating you if you revoke this consent.

_____ I acknowledge a copy of this office's Notice of Privacy Practices is available to me at my request.

_____ I hereby authorize payment to this practice of the insurance benefits otherwise payable to me and recognize and accept personal responsibility of any remaining balance. Please check the following that apply:

____ OK to leave a message regarding appointment, insurance information, call back requests, etc. on my home phone and/or cell phone.

_____ OK to leave a message regarding appointment, insurance information, call back requests, etc. with a family member.

____ OK to leave a message regarding appointment, insurance information, call back requests, etc. on my work phone.

Please list any and all persons we can speak to on your behalf:

_____

_____

_____

_____

Signature of Patient **Date**

1532 150th Ave 27206 Calaroga Ave. #205 19845 Lake Chabot Rd #211 2333 Mowry Ave #300 San Leandro, CA 94578 Hayward, CA 94545 Castro Valley, CA 94546 Fremont, CA 94538 Phone: (510) 351-6363 Phone: (510) 670-1111 Phone: (510) 582-6966 Phone: (510) 670-1111 Fax: (510) 278-3757 Fax: (510) 670-4772 Fax: (510) 582-5632 Fax: (510) 670-4772

EAST BAY
CARDIOVASCULAR
& MEDICAL SPECIALIST

East Bay Cardiovascular and Medical Specialist
Terms and Conditions of Service

Please, read this document carefully. Dr. Aditya Jain MD Inc, doing business as East Bay Cardiovascular and Medical Specialist requires that Terms and Conditions of Service be signed in its entirety, without alteration, and patient registration forms are to be completed on as needed basis. Terms of Agreement: I understand that the terms and conditions in this agreement will remain in effect indefinitely unless there are changes in information. I understand I will be asked to confirm that my demographic and insurance information is correct at each office visit. If my insurance or demographic information has changed, I will inform the office staff and provide the needed documentation.

Medical Consent: I, the undersigned patient or legal representative, consent to the general treatment and procedures that may be performed. These procedures may include but are not limited to laboratory procedures, medical or surgical treatment, special diagnosis, vaccines, or therapeutic procedures. I understand and agree that at the request of the attending physician, health practitioners (such as nurse practitioners) may participate in my care.

Photography/Telehealth: I consent to the taking of photos, videos, or electronic image reproductions of any information in my medical record, including surgical treatment information. I consent to the evaluation by a physician/nurse practitioner via virtual technologies/telephone as determined by the providers by telehealth medicine methods for as long as the public health emergency stays in effect and/or until my insurance provides an end date. I understand that my digital image in any form may be used by providers for quality improvement, patient safety, education, and security.

Financial Agreement: I accept full financial responsibility for services not covered by my medical insurance: Co-Pays, Co-Insurance, balance, and Deductibles. This also includes services or supplies not covered by my health insurance plan or Medicare. Should my account be referred to an attorney or a collection agency for collection, I further agree to pay actual attorney's fees and lawsuit-related collection agency incurred in addition to other amounts due. Assignment of Insurance Benefits (Including Medicare Benefits): I authorize Dr. Aditya Jain MD, Inc., doing business as East Bay Cardiovascular and Medical Specialist to bill my insurance(s) on my behalf, and direct payment to be made to Dr. Aditya Jain MD, Inc., doing business as East Bay Cardiovascular and Medical Specialist. I am responsible for providing information to my provider office if I have dual coverage or more than one insurance plan at the time of the service. I may be held responsible for payment if the time filing limit to submit a claim has expired, If the billing department did not have my insurance information at the time of billing. I authorize the release of medical information to my insurance company, pharmacy, or another party to assist in my medical care, or payment of my claims.

Returned Fee Checks: A fee of **$30.00** is charged for returned checks in addition to the amount of the check. Release of Information: In compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), East Bay Cardiovascular and Medical Specialists will provide the patient with a Notice of Privacy Practices, which describes how medical information about you may be used and disclosed, and how you can get access to this information. Additional copies are available at any reception desk. Call the office

manager with any questions at (510) 351-6363.

We reserve the right to refuse service to anyone who does comply with the office policies, medical advice and the provider orders as mandated by their insurance companies. Also, anyone who is rude, boisterous, threatening in any shape or form to office staff, providers, and patients will be discharged from the practice

You will be asked to produce identification, insurance card and payment (if applied) at each office visit.

The undersigned certifies that he/she has read the Terms and Conditions of Service, and is the patient or is duly authorized by or on behalf of the patient to execute and accept its terms.

Full Name (print) Signature Date

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EAST BAY CARDIOVASCULAR & MEDICAL SPECIALIST

EBCMS

CANCELLATION POLICY

Dear Valued Patients of EBCMS,

Effective (revised) 2025 our practice will respectfully require an advance **TWENTY-FOUR (24) HOUR cancellation** of your scheduled appointment and / or scheduled office test. This policy is effective for NO Show Appointments and less than 24 hours of cancelling your appointment and/ OR scheduled test.

If a No Show or Late Cancellation occurs, it greatly affects our practice and ability to see other patients. You WILL be billed a FEE of **$50.00.**

We understand that sometimes schedule adjustments are necessary. With that, an EBCMS medical staff member will call you one week to forty-eight (48) hours prior to your scheduled appointment to confirm. We will leave a message on your voicemail if we do not reach you.

In accordance with EBCMS Cancellation Policy, you will be billed **$50** (as described above) and that will be your financial responsibility.

Thank you for your cooperation. Our providers and staff look forward to assisting you in your health needs and are available if you have any questions or concerns.

Sincerely,
EBCMS Administration

_____ _____

Name (Please Print) Date of Birth

_____ _____

Signature Date

1532 150th Ave
San Leandro, CA 94578
Phone: (510) 351-6363
Fax: (510) 278-3757

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AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?[1]
   - ☐ Yes
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[4]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

12. How often does anyone, including family, insult or talk down to you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

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Advancing health equity in every community

13. How often does anyone, including family, threaten you with harm?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

ASSISTANCE

15. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: _____
Greater than 10 equals positive screen for personal safety.

REFERENCES

1. https://www.va.gov/HOMELESS/Universal_Screener_to_Identify_Veterans_Experiencing_Housing_Instability_2014.pdf
2. Nuruzzaman N, Broadwin M, Kourouma K, Olson DP. Making the social determinants of health a routine part of medical Care. *J Health Care Poor Underserved.* 2015;26(2):321-327.
3. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics.* 2010;126(1):e26-e32.
4. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics.* 2008;122(4):e867-e875.
5. Children's HealthWatch. Final: 2013 Children's Healthwatch survey. http://www.childrenshealthwatch.org/methods/our-survey/. Accessed October 3, 2018.
6. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE project. *Pediatrics.* 2007;120(3):547-558.
7. Aldana SG, Liljenquist W. Validity and reliability of a financial strain survey. *J Financ Couns Plan.* 1998;9(2):11-19.
8. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med.* 1998;30(7):508-512.

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION *Supported in part by a grant from the AAFP Foundation*

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐