NEW BEATS CARDIOLOGY

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Patient Information

Today's Date: _____

Name (Last) _____ (First) _____ (Middle)_____

DOB: _____ Sex: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

□ I would like to receive text reminders of my upcoming appointments

Email: _____

Emergency Contact: _____ Relationship: _____Phone: _____

Pharmacy: _____ Phone: _____

Primary Insurance

Name of Insurance: _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____

Relation to Patient: _____ Social Security Number: _____

Secondary Insurance

Name of Insurance: _____

ID#: _____ Policy #: _____

Policy Holder's Name: _____ DOB: _____

Relation to Patient: _____ Social Security Number: _____

Assignment and Release

• I hereby authorize New Beats Cardiology to bill my insurance carrier and assign benefits to be paid directly to the physician(s) at New Beats Cardiology.

• I understand that I am financially responsible for all non -covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.

• I authorize the physician to release any medical information required to process any claims.

• I authorize my provider's office to contact me by telephone to remind me of my appointments.

Signed: _____ Date: _____

Past Cardiovascular History:

Do you or have you had any of the following? Please check if YES.

☐ Abnormal EKG
☐ Aortic Aneurysm/Dissection
☐ Hyperlipidemia (high cholesterol)
☐ Cardiac Bypass Surgery (CABG)
☐ Cardiomyopathy
☐ Congenital Heart Disease (childhood)
☐ Congestive Heart Failure
☐ Coronary Artery Disease (Blocked Arteries)
☐ Coronary Stent (PCI)
☐ Deep Vein Thrombosis/DVT (leg blood clot)
☐ Valve Stenosis (tight valve)
☐ Valve Regurgitation (leaky valve)
☐ Ventricular Septal Defect (VSD)
☐ Hypotension (low blood pressure)
☐ Hypertension (high blood pressure)
☐ Murmur (extra heart sound)
☐ Pacemaker/ICD (defibrillator) CRT
☐ Pericarditis
☐ Pulmonary Embolism (lung blood clot)
☐ Pulmonary Hypertension
☐ Rheumatic Heart Disease
☐ Stroke/ Cerebrovascular disease
☐ Diabetes Mellitus (type I or type II)
☐ Heart Attack
☐ Vascular Surgery
☐Heart Surgery (Any other not listed i.e valve)

ANSWER IF APPLICABLE: (Please circle answer)

Past Cardiac Testing History	NO/YES	Date	Normal/Abnormal
24-hour Rhythm Monitor (Holter)	N / Y		NL / ABN
Event Monitor	N / Y		NL / ABN
Echocardiogram	N / Y		NL / ABN
Stress Test	N / Y		NL / ABN
Stress Echocardiogram	N / Y		NL / ABN
Stress Nuclear Test	N / Y		NL / ABN
Cardiac Catheterization	N / Y		NL / ABN
Electron Beam CT/Calcium Score	N / Y		NL / ABN
OTHER:			

MEDICATIONS: List of ALL medications that you are currently taking including non-prescription medications & herbal remedies. Or provide the office with a copy of your list of Medications.

MEDICATION	DOSE	HOW OFTEN?	APPROXIMATE START DATE (MONTH AND YEAR)

ALLERGIES OR SENSITIVIY TO MEDICATIONS:

Allergic to:	Severity:

GENERAL PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY (MAJOR ONLY: Cardiovascular and General)

Year	Major Surgery

FAMILY HISTORY: Questions will pertain to only first-degree relatives (i.e. parents, brothers/sisters, and children) in your family. Do any of your first -degree relatives have any of the following? Please circle **Y / N** to the questions listed below, and if yes please explain relationship.

Type	NO/YES	Relationship w/ Family Member
Premature heart blockage or heart attack?	N / Y	
Heart failure or Cardiomyopathy?	N / Y	
Sudden cardiac death or unexplained death?	N / Y	
Abnormal heart rhythm?	N / Y	
Any other cardiac disease not yet mentioned?	N / Y	

1. Is your father alive? N / Y Age: ____ If deceased, at what age? ____ Cause if known: _____

2. Is your mother alive? N / Y Age: ____ If deceased, at what age? ____ Cause if known: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to the office, New Beats Cardiology, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of New Beats Cardiology reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of New Beats Cardiology may call my home or other alternative location and leave a message on voicemail or in person, in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including testing and laboratory results.

With this consent, the office of New Beats Cardiology may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of New Beats Cardiology may e -mail to my home or other alternative location on any occasion that assists the practice in carrying out TPO, such as, appointment reminders and patient statements. I have the right to request that the office of New Beats Cardiology restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of New Beats Cardiology may use and disclose my PHI to carry out TPO. I may revoke my consent in writing, except for services already rendered, according to my prior consent. If I do not sign this consent, or later revoke it, the office of New Beats Cardiology may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian Date

_____

Patient's Printed Name

_____

Printed Name of Patient or Legal Guardian Date

FINANCIAL PAYMENT POLICY

We find that communication with our patients regarding our financial policy assists us in providing the best service for you. We have therefore taken the time to answer some of the most asked questions. **How can I pay?**

We accept payment by cash, chec k, VISA, MasterCard, Discover, and American Express.

What is my financial responsibility for services?

Your financial responsibility depends on a variety of factors, explained below.

If you have	**You are responsible for .....**	**Our staff will .....**
Commercial Insurance **Medicare** **Medicare Replacement**	Payment of the patient responsibility for all office visits, injections, office procedures and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the service's, you receive are covered by the plan: All applicable copays and deductibles are requested at the time of visit If the service's, you receive are not covered by the plan: Payment in full is requested at time of visit.	File an insurance claim on your behalf.
HMO with which we are not contracted and are not applying for	Payment in full for office visits, injections, office procedures and other charges at the time of visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility – deductible, copay, non -covered services -at the time of the visit.	File an insurance claim on your behalf.
No Insurance	Payment in full required at the time of service.	

We feel strongly that it is the patient's responsibility to be aware of the requirements and limitations of their own benefits and insurance plans. Please let our office know if your insurance has requirements regarding participating in outpatient facilities and laboratories. For services rendered in our office and outpatient facilities please note that you may also receive bills from other non-New Beats Cardiology entities for services rendered in conjunction with your care (i.e., laboratory services, hospital services).

Any patient who is seen and fails to notify our office of any changes in their insurance, that in turn deems their services as non-covered, will be billed directly for these charges. In exchange for filing your insurance, you agree to provide current insurance information and picture I.D at every office visit. We understand that filling out forms is at times tedious; we do our best to simplify this process.

Co-pays are required at the time of the visit.

Check Policy

We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as an NSF (or for any other reason), you will be assessed a $35 service fee plus the amount of the original check. You may be required to make future payments using cash, credit card or order.

I have read, understand, and agree with the above Financial Policy. I understand that charges that are not covered by my insurance company, as well as applicable co-payments, deductibles, and coinsurance amounts, are my responsibility.

_____ _____ _____

Date Signature Printed Name

Permission of Release of Records

Date: _____

I _____, give permission for the following individuals
(Name of Patient)
to obtain copies of my medical records and/ or any medical information pertaining to my care at New Beats Cardiology.

Name	Relationship	Phone number

Patient's Printed Name: _____ Patient's Date of Birth: _____

Patient's Signature: _____

Guardian's Signature: _____