ALI R. MOOSVI, M.D., FACP, FACC
TODD S. COHEN, D.O., FACC
MICHAEL G. DEVITA, D.O., FACC
EUGENE S. KOFMAN, M.D.

COLLEEN E. DEPAUL, RN, MSN, APN-C
CHRISTINA M. YANNONE, PA-C
PAUL J. LAMARTINA, PA-C

FAX: 732.840.0355
www.shorecardiology.com

Patient Information:

Last Name: ___________________________ First Name: ___________________________ Middle Initial: _________
DOB: ______________________ Age: ___________ SS#: __________________ Gender: ☐ Male ☐ Female
Address: ____Apartment:____________________
City: ________________________________ State: _______________________________ Zip: ___________________
Home Phone: ______________________ Cell Phone: __________________ Work Phone: _____________________
Lab Company: ☐ LabCorp ☐ Quest ☐ JSMC/OMC Outpatient Labs ☐ Other: _______________________________
E-Mail: _________________________@____________________ *Sign me up for Patient Portal: ☐ Yes ☐ No*
Are you currently on Active Duty?: ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner
Employer Name: _________________________________ Employer Address: ________________________________

Emergency Contact: *NUMBER MUST BE OTHER THAN YOURS*

Last Name: ___________________________ First Name: ___________________________
Address: ________________________________City: ________________________________ State: _____ Zip: __________
Relationship to patient: _____________________ Home Phone: ______________ Cell Phone: _________________

Insurance & Payment Information:

Person responsible for the bill (IF DIFFERENT THAN THE INSURED)

Last Name: ___________________________ First Name: ___________________________ Middle Initial: _________
DOB: ______________________ Age: ___________ SS# __________________ Gender: ☐ Male ☐ Female
Address: ____Apartment:____________________
City: ________________________________ State: _______________________________ Zip: ___________________
Home Phone: ______________________ Cell Phone: __________________ Work Phone: _____________________
Employer Name: _________________________________ Employer Address: ________________________________

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Address if not the same:	Policy Holder's Address if not the same:
Policy Holder's D.O.B:	Policy Holder's D.O.B:
Policy Holder's ID#:	Policy Holder's ID#:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:
Employer Name:	Employer Name:

Additional Information:

Primary Care Physician Name/Address/Telephone: ____
____

Preferred Pharmacy Name/Address/Telephone: ____
____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic Native
☐ Hawaiian or Pacific Islander ☐ White ☐Other: _______________ ☐ Decline
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐Other: ___________________ ☐ Decline
Preferred Language: ☐ English ☐ Spanish ☐ Hindi ☐ Tamil ☐ Russian ☐ Sign Language ☐ Other ______________

ALI R. MOOSVI, M.D., FACP, FACC
TODD S. COHEN, D.O., FACC
MICHAEL G. DEVITA, D.O., FACC
EUGENE S. KOFMAN, M.D.

COLLEEN E. DEPAUL, RN, MSN, APN-C
CHRISTINA M. YANNONE, PA-C
PAUL J. LAMARTINA, PA-C

FAX: 732.840.0355
www.shorecardiology.com

Agreement of Financial Responsibility:

• Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

• It is <u>your</u> responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, referrals, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement, if applicable.

• Proof of payment and photo ID is required. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverage have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

• Please understand that if your insurance company denies coverage and/or payment for services provided to you, you will be financial responsibility to pay all such charges in full.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

____ ____________________________
Signature of Patient / Parent or Guardian Date

____ ____________________________
Name of Patient / Parent or Guardian (please print) Relationship to Patient

ALI R. MOOSVI, M.D., FACP, FACC
TODD S. COHEN, D.O., FACC
MICHAEL G. DEVITA, D.O., FACC
EUGENE S. KOFMAN, M.D.

COLLEEN E. DEPAUL, RN, MSN, APN-C
CHRISTINA M. YANNONE, PA-C
PAUL J. LAMARTINA, PA-C

FAX: 732.840.0355
www.shorecardiology.com

Acknowledgment of Receipt of Notice and Approval of Privacy Practices

I, ______________________________, hereby acknowledge that I have received the corresponding HIPAA Notice of Privacy Practices. I also further acknowledge and approve the uses and disclosures of my PHI as described in the HIPAA Notice of Privacy Practices.

Date: __________________, 20________ ____

Signature of Patient or Representative

Patient Contact Authorization

I, ____ (Please Print Name) authorize and give permission to Shore Cardiology Consultants, LLC or any practice staff members, to leave messages regarding my medical information on the following telephone(s):

Home: ( ) ___________________

Cell: ( ) ___________________

I authorize and give permission to Shore Cardiology Consultants or any practice staff member, to speak with the following people regarding my medical status and/or treatment:

Name: ________________________________ Relationship: ________________________________

Name: ________________________________ Relationship: ________________________________

Name: ________________________________ Relationship: ________________________________

Patient Signature: ________________________________ Patient DOB: _______________________

Consent to Obtain Medication History

Our computer system allows us to collect and review your “medication history.” A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. I understand that I have the right to revoke or change this authorization at any time after giving notification in writing to Shore Cardiology Consultants, LLC.

☐ I authorize ☐ I do **NOT** authorize

ALI R. MOOSVI, M.D., FACP, FACC
TODD S. COHEN, D.O., FACC
MICHAEL G. DEVITA, D.O., FACC
EUGENE S. KOFMAN, M.D.

COLLEEN E. DEPAUL, RN, MSN, APN-C
CHRISTINA M. YANNONE, PA-C
PAUL J. LAMARTINA, PA-C

FAX: 732.840.0355
www.shorecardiology.com

INSURANCE AND BILLING POLICIES

INSURANCE: Shore Cardiology Consultants submits claims to participating insurance carriers. Your insurance information is required at **EACH** visit for our office to submit a claim to your primary insurance plan. It is your responsibility to notify Shore Cardiology Consultants of any change or termination of your insurance.

TESTING: If you do not cancel your test 1 business day in advance you will be billed the following fee(s) that apply. Nuclear Stress test: $65.00 Exercise stress test: $25.00 Echocardiogram: $25.00 All vascular testing (Carotid, Bilateral upper arterial/venous, Bilateral lower arterial/venous, Mesenteric, AAA, Aorta-iliac, Bilateral renal): $30.00

REFERRALS/AUTHORIZATIONS: It is your responsibility to make sure that a referral has been obtained from your Primary Care Physician and provided to our office. If you do not have the referral you may be asked to reschedule your appointment, or pay in full for services that day.

CO-PAYS, CO-INSURANCE AND DEDUCTIBLES: Co-pays will be collected prior to your office visit. If you ask to be billed, a $5.00 fee will be added to that bill. If a coinsurance or deductible is applied as your responsibility instead, you will be billed for the additional amount once your insurance processes the claim.

MEDICARE: Our doctors are participating with Medicare Part B and we will bill for services provided. You will be responsible for any deductible or co-insurances. We will submit to a secondary insurance as a courtesy. If you would like to submit to your secondary insurance, we will gladly issue you a receipt for services rendered.

WORKER'S COMP & MOTOR VEHICLE ACCIDENTS: We will bill the insurance carrier directly. You are responsible for providing the complete claim information, claim address, adjuster's contact information. If your worker's comp or PIP insurance denies your claim, we will then bill your medical insurance if the appropriate information and referrals needed were provided in a timely manner. We will NOT await the results of any litigation to receive payment. We do NOT accept "Letters of Protection". You will be billed for any patient co-insurance and deductible or if the claims are denied. You will be responsible for payment in FULL.

SELF PAY: If you do not have medical insurance coverage, payment in full is required at the time of service.

AUTHORIZATIONS: Prior authorizations are required by some insurance plans for certain testing and radiology services. It is your responsibility to know your insurance and make sure all necessary requirements are obtained prior to receiving these services. If an authorization/referral is not obtained, you may have to reschedule. If you have a test at an outside hospital or facility without obtaining the correct authorizations or referrals, they may bill you for the services rendered.

RETURNED CHECKS: If a check you issued as payment is returned by your bank (for any reason), you will be charged a fee of $30.00. Any future payments to our office must be made by cash or credit/debit card ONLY.

I have read and understand the above policy regarding my financial responsibility to Shore Cardiology Consultants, LLC. My failure to fulfill my financial obligations may cause interruptions or delays in my care.

____ ____________________________
Signature of Patient / Parent or Guardian Date

____ ____________________________
Name of Patient / Parent or Guardian (please print) Relationship to Patient

ALI R. MOOSVI, M.D., FACP, FACC
TODD S. COHEN, D.O., FACC
MICHAEL G. DEVITA, D.O., FACC
EUGENE S. KOFMAN, M.D.

COLLEEN E. DEPAUL, RN, MSN, APN-C
CHRISTINA M. YANNONE, PA-C
PAUL J. LAMARTINA, PA-C

FAX: 732.840.0355
www.shorecardiology.com

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to Shore Cardiology Consultants, LLC and/or our providers for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Shore Cardiology Consultants, LLC and/or our providers, to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

I have requested medical services from Shore Cardiology Consultants, LLC and/or our providers, on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

My signature below constitutes my acknowledgment of the above:

____   _______________________________
Signature of Patient / Parent or Guardian   Date

____   _______________________________
Name of Patient / Parent or Guardian (please print)   Relationship to Patient

ALI R. MOOSVI, M.D., FACP, FACC
TODD S. COHEN, D.O., FACC
MICHAEL G. DEVITA, D.O., FACC
EUGENE S. KOFMAN, M.D.

COLLEEN E. DEPAUL, RN, MSN, APN-C
CHRISTINA M. YANNONE, PA-C
PAUL J. LAMARTINA, PA-C

FAX: 732.840.0355

Health Insurance Portability and Accountability Act and Circle of Care

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 Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI.

"PHI" 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 Disclosures of PHI: Your PHI may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law. Shore Cardiology Consultants LLC participates in Circle of Care. Circle of care is the sharing of your PHI, that information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care 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. Your Circle of Care physicians will be listed in your patient chart.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Your PHI 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 PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant PHI be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your PHI, as necessary, to contact you to check the status of your equipment.

We may use or disclose your PHI in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation.

Required Uses and Disclosures: By law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

ALI R. MOOSVI, M.D., FACP, FACC
TODD S. COHEN, D.O., FACC
MICHAEL G. DEVITA, D.O., FACC
EUGENE S. KOFMAN, M.D.

COLLEEN E. DEPAUL, RN, MSN, APN-C
CHRISTINA M. YANNONE, PA-C
PAUL J. LAMARTINA, PA-C

FAX: 732.840.0355
www.shorecardiology.com

Health Insurance Portability and Accountability Act and Circle of Care continued

Required Uses and Disclosures: Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. 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 obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically. You may have the right to have our organization amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail, text or email of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI.
Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

My signature below constitutes my knowledge of the above:

Name: ____ Birth Date: ____-______-_____

Signature: ____ Date Signed: _______________