SHORE CARDIOLOGY CONSULTANTS, LLC

Ali R. Moosvi, M.D., FACP, FACC
Todd S. Cohen, D.O., FACC
Michael G. DeVita, D.O., FACC
Roy B. Sauberman, M.D., FACC
Colleen E. DePaul, RN, MSN, APN-C
Christina M. Celmer, PA-C

Phone: 732.840.1900
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:

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____Apartment:_____
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 ☐ Decline
Preferred Language: ☐ English ☐ Spanish ☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Sign Language ☐ Other

SHORE CARDIOLOGY CONSULTANTS, LLC

Ali R. Moosvi, M.D., FACP, FACC
Todd S. Cohen, D.O., FACC
Michael G. DeVita, D.O., FACC
Roy B. Sauberman, M.D., FACC
Colleen E. DePaul, RN, MSN, APN-C
Christina M. Celmer, PA-C

Phone: 732.840.1900
Fax: 732.840.0355

www.shorecardiology.com

Agreement of Financial Responsibility:

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to, prior to any treatment.

• 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 your 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 are required for all patients. 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 has Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are 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

SHORE CARDIOLOGY CONSULTANTS, LLC

Ali R. Moosvi, M.D., FACP, FACC
Todd S. Cohen, D.O., FACC
Michael G. DeVita, D.O., FACC
Roy B. Sauberman, M.D., FACC
Colleen E. DePaul, RN, MSN, APN-C
Christina M. Celmer, PA-C

Phone: 732.840.1900
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. It is very important for us to know what you are taking including any over the counter medicines, supplements, or herbal remedies. 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

A photocopy of these assignments shall be valid as the original.

SHORE CARDIOLOGY CONSULTANTS, LLC

Ali R. Moosvi, M.D., FACP, FACC
Todd S. Cohen, D.O., FACC
Michael G. DeVita, D.O., FACC
Roy B. Sauberman, M.D., FACC
Colleen E. DePaul, RN, MSN, APN-C
Christina M. Celmer, PA-C

Phone: 732.840.1900
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 Dr. Ali Moosvi, M.D., Dr. Todd Cohen, D.O., Dr. Michael DeVita, D.O., Dr. Roy Sauberman, M.D., Colleen DePaul, APN-C, 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 Dr. Ali Moosvi, M.D., Dr. Todd Cohen, D.O., Dr. Michael DeVita, D.O., Dr. Roy Sauberman, M.D., Colleen DePaul, APN-C, 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. This order will remain in effect until revoked by me in writing.

I have requested medical services from Shore Cardiology Consultants, LLC and/or Dr. Ali Moosvi, M.D., Dr. Todd Cohen, D.O., Dr. Michael DeVita, D.O., Dr. Roy Sauberman, M.D., Colleen DePaul, APN-C, 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

A photocopy of these assignments shall be valid as the original.