Cardiology Consultants of North Morris, P.A.

356 Route 46, Mountain Lakes, NJ 07046, Tel: 973-586-3400 Fax: 973-586-1916

Your Appointment Date & Time: _____

Please come 15 minutes ahead of time.

Welcome to our Office:

If you have not already done so, please complete the new patient forms prior to your appointment in our office. Please complete detailed list of any and all medications you are taking as this is particularly important for the physician.

Please remember to bring your insurance card(s) as well as a photo I.D. with you when you come in.

IF YOUR INSURANCE REQUIRES A REFERRAL – PLEASE OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR APPOINTMENT. YOU WILL NOT BE ABLE TO BE SEEN WITHOUT A REFERRAL IF YOUR INSURANCE REQUIRES ONE. PLEASE CHECK WITH YOUR INSURANCE CARRIER IF YOU ARE UNCERTAIN IF YOUR POLICY REQUIRES ONE.

Thank you for Your Assistance,

Cardiology Consultants of North Morris
Atlantic Medical Group
(Formerly known as Practice Associates Medical Group)
356 Route 46
Mountain Lakes, NJ 07046

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In regard to your upcoming appointment, information sheets have been enclosed which may be completed at home. Please bring them and your MEDICAL INSURANCE CARDS with you on your appointment day.

If you are covered by MEDICARE, you will be pleased to know that your doctors are Participating Physicians, and you will be required to pay only the 20% at the time of service.

If you are covered by an HMO, it is imperative that you bring a referral form or referral number from your Primary Care Physician. All copays will be collected at time of visit. We accept CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS CARD.

Please bring any medical records and/or copies of any tests you have had in the past year, related to a cardiac condition. It is very important that we are also informed of all medications that you are currently taking. These will be listed in your chart. In the event that an EKG may be required, we would advise that you please wear clothing that allows for easy access to the upper body. For our female patients, pantyhose should not be worn.

If you are being sent for any testing from your Primary Care Physician please bring your prescription to the appointment.

We look forward to having you as a patient. If you have any questions or concerns, please feel free to give us a call at the office, Monday through Friday between 9:30am and 4:30 pm at (973) 586-3400. Thank you again for allowing us to take part in your cardiac care.

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INFORMATION FOR OUR MEDICARE PATIENTS

Routine Waiver of Copayments or Deductibles Unlawful

The Medicare **deductible** is the amount that must be paid by a Medicare patient before Medicare will pay for any services for that individual. Currently, the Medicare Part B deductible is $257.00 per year.

Copayment (or coinsurance) is the portion of the cost of a service which the Medicare patient has to pay. Currently, Medicare Part B copayment is 20 percent of the Medicare allowed amount. If the Medicare allowed amount is $100.00, the Medicare patient (who has met his/her deduction) must pay 20% ($20.00) of the physician's bill, and Medicare will pay 80%.

In certain cases, a physician who routinely waives Medicare copayments or deductibles could be held liable under the Medicare and Medicaid anti-kickback statute, 42 U.S.C. 1320a-7b(b). This statute makes it illegal to offer, pay, solicit, or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When physicians routinely forgive the debt for financial hardship without specific information from a patient to justification, they may be unlawfully inducing that patient to purchase services.

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****** PLEASE FILL OUT ALL SPACES ******

PATIENT INFORMATION

Name (Last, First, MI)	Social Security #	Date of Birth	Age	Sex	Marital Status

Race	Ethnic Origin	Primary Language	Home Phone	Cell Phone	Work Phone

Street Address	City	State	Zip Code

Mailing Address (if Different than above)	City	State	Zip Code

E-Mail Address

Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student	Employer Name	Occupation

Employer Address	City	State	Zip Code

Insurance Information

Primary Insurance Company	Subscriber's Name	Date of Birth	Relationship	Policy Number	Group Number
Second Insurance Company	**Subscriber's Name**	**Date of Birth**	**Relationship**	**Policy Number**	**Group Number**

****Fill out only if patient is not Subscriber OR is a Married Medicare Patient (For Medicare Questionnaire Purposes) ****

Name of Subscriber OR Patient's Spouse	Social Security #	Date of Birth	Sex	Relationship to Patient

Street Address	City	State	Zip Code	Home Phone
Employer Name and Address	**City**	**State**	**Zip Code**	**Work Phone**

*** **PRIMARY PHYSICIAN** ***	Referring Physician

Emergency Contact Information

Contact Name (Last, First, MI)	Relationship	Primary Phone Number	Secondary Phone Number

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: _____ Date: _____

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PATIENT/FAMILY CONTACT COMMUNICATION

ONLY PERSONS LISTED ON THIS FORM MAY BE GIVEN DETAILED PATIENT INFORMATION

PRIMARY CONTACT NAME:	RELATIONSHIP:
HOME #:	BUSINESS:
CELL:	EMAIL ADDRESS:
SECONDARY CONTACT NAME:	RELATIONSHIP:
HOME #:	BUSINESS:
CELL:	EMAIL ADDRESS:
ADDITIONAL CONTACT NAME:	RELATIONSHIP:
HOME #:	BUSINESS:
CELL:	EMAIL ADDRESS:
OTHER PERTINENT INFORMATION:	
MAY WE LEAVE A MESSAGE ON YOUR HOME ANSWERING MACHINE? CIRCLE ONE YES NO	
PATIENT SIGNATURE:	**DATE:**

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FINANCIAL POLICY STATEMENT

To help out patients fully understand our billing process, we ask that you read and sign our financial policy statement.

As a courtesy to you, Cardiology Consultant of North Morris, P.A. will submit a claim to your insurance carrier. Depending upon your individual policy, your coverage, your deductible and/or co-payment requirements, you may be billed for the balance.

Although Cardiology Consultant of North Morris, P.A. participates with most insurance carriers, *it is your responsibility* at the time of service to verify with your insurance carrier if the particular physician, or the service/test that you are scheduled to have is accepted by your plan.

For claims not submitted as a courtesy, Cardiology Consultant of North Morris, P.A. accepts cash, checks, debit cards, Discover Card, MasterCard or Visa for payment. For insurance plans that do not allow courtesy submission of claims, you must pay at the time of service.

When our doctor participates fully in your insurance plan, you are still responsible for paying any co-insurance, deductible of co-payment(s) as indicated by your carrier, as well as any non-covered service(s) under their contract. Once payment has been made or payment has been denied by the insurance company you will be billed and be responsible to pay the balance.

You are responsible for bringing the necessary referral(s) to the office on the day of your appointment. If you do not have the required referral form(s) on the day of the appointment, you are responsible for payment at the time of service and must sign a waiver.

Although Cardiology Consultant of North Morris, P.A. may on occasion, as a courtesy to you file private insurance claims, we will not become involved in disputes between you and your insurance carrier regarding covered charges, secondary insurance issues or “usual and customary” charges other than supply factual information as requested by the insurance carrier.

THANK YOU FOR TAKING THE TIME TO REVIEW THE CARDIOLOGY CONSULTANT OF NORTH MORRIS, P.A. FINANCIAL POLICY STATEMENT. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS, COMMENTS OR SPECIAL CONCERNS!

Responsible Party Signature: _____ Date: _____

PRINT NAME: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patients Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

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MEDICAL HISTORY

Name: _____ Date: _____

Why are here to see the Cardiologist? _____

Referred by: _____

Check off any heart problems or symptoms

- ☐ Heart Attack
- ☐ Angina
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Abnormal Rhythm (Arrhythmia)
- ☐ Palpitations, Irregular Heartbeats
- ☐ Fainting
- ☐ Enlarged Heart
- ☐ Chest Pains or Pressure
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Swollen Legs
- ☐ Heart Failure
- ☐ Blue Lips or Fingermails
- ☐ Leg Cramps when you walk
- ☐ Stroke

Have you ever had:

- ☐ Exercise Stress Test
- ☐ Echocardiogram
- ☐ Cardiac Catheterization
- ☐ Coronary Angioplasty (Ballon)
- ☐ Coronary Bypass Surgery
- ☐ Valve Surgery
- ☐ Electrophysiology Study or Procedure
- ☐ Pacemaker or Defibrillator

Please check if you have:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Ever Smoked
- ☐ Diabetes

Have you had any operations/injuries/hospitalizations

_____

_____

Tell us about Yourself:

Marital Status: ☐ S ☐ M ☐ W ☐ D Children

With Whom do you live? _____

Occupation: _____

Leisure Activities: _____

Exercise Routine: _____

Health Habits:

Do you currently smoke? _____

Have you ever smoked? _____

Packs per day? _____ How many years? _____

Alcohol? _____ Caffeine? _____

Are you being treated or have you been treated for any chronic illness? Please list them

_____

_____

_____

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MEDICATION LOG

Patient: _____ **Birthdate:** _____

Home Phone: _____ **Cell Phone:** _____

Pharmacy: _____ **Pharmacy Phone:** _____

MEDICATION	*DOSAGE*	FREQ.

Are you allergic to any Medications / IV Dyes / Shellfish?

_____

What kind of reaction did you have?

_____

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND OBTAINED ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CARFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used of disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example would be a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending your bill for a visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. And example would be an internal quality assessment review.

We may also create and distribute de-identified health information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by is unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 14, 2003** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protection have been violated. You have the right to file written complaints with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of this office. We will not retaliate against you for filing a complaint.

For more information about HIPAA:
The U.S. Dept of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257

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Cultural Competency:

State of New Jersey mandates that every physician documents any barrier to care including cultural and linguistic needs in the medical record. Factors affecting care are visual or auditory factors, which may impede the member's ability to comprehend medical discussion, language, cultural and/or religious customs, which may impact the provider's ability to provide medical care. Addressing these needs will improve patient satisfaction and also decrease health care disparities. When documenting cultural competency in the member's medical record, it's imperative to document if no barriers exist.

Barriers – Yes or no (circle one)

Do you have any impairment- (i.e. visual, hearing, speech, learning, physical, and language/cultural barrier)?

What language do you speak, read, and write?

Do you have any religious or cultural customs that the doctor should know about?

Yes No

If yes please describe.

Advance Directives:

Advance Directives is the federal and state mandated Self-Determination Act enacted in 1990. This allows the patient to provide specific instruction and direction regarding his or her own medical care wishes if they become incapacitated. The patient-physician relationship provides a direct opportunity for you to discuss these types of decisions with your patient. Physicians need to ask and document in the medical record for all patients who are 18 years of age and older.

Do you have a "Living Will" or Advance Directives?

Yes No

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

Kindly be advised:

All tests are considered
Out-patient procedures in an Atlantic Health Facility,
and as such, may have different requirements for deductibles
and/or copays than your doctor visits.

Please check with your insurance company to verify
coverage and out-patient policies.

Morristown
Medical Center
~~ATLANTIC HEALTH SYSTEM~~

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Diplomates-Cardiovascular Disease / American Board of Internal Medicine

Robert L.Wang, M.D., F.A.C.C.
Ronald D. Massari, M.D., F.A.C.C.
Benjamin Fusman, M.D., F.A.C.C.
Stuart E. Shulruff, M.D., F.A.C.C.
Guillermo A. Cook, M.D., F.A.C.C.
Jordan G. Safirstein, M.D., F.A.C.C.
Mehmood Riaz Ahmad, MD, FACC, FACP

July 13, 2012

Dear Patient:

In order to meet the challenges of a rapidly evolving healthcare economy, we at Cardiology Consultants of North Morris anticipate that physicians and hospital systems will need to collaborate more closely in the future to provide quality health care services to the community we serve. ***Therefore, Cardiology Consultants of North Morris is pleased to announce that it is partnering with Atlantic Health System in a new strategic alignment as of 08/01/2012.*** Atlantic Health is one of the leading health systems in Northern New Jersey and includes Overlook, Newton and Morristown Medical Centers.

This partnership will further strengthen our stated mission to provide the highest quality medical evaluations and treatments for you and your family, by coordinating your care and streamlining communication between the outpatient and inpatient settings.

Your care will be provided by the SAME physicians in the SAME office locations. Our physicians will continue to provide emergency and inpatient services for you at Morristown Medical Center and Saint Clare's Hospital, Dover and Denville Campuses.

Non-invasive testing services will continue to be provided in main offices under the auspices of Atlantic Health.

As we embark on this new endeavor, there will be several changes to our registration and billing process. *Please note that bills for all of our physician's services after 08/01/2012 will come from Practice Associates Medical Group. Due to our hospital affiliation, the technical portion of any testing done in our office will be billed separately.*

Rest assured that our office staff will continue to coordinate your care. Thank you for your cooperation as we strive to provide you and your family with exceptional care and service.

Sincerely,

Cardiology Consultants of North Morris, P.A.

Robert L. Wang, M.D

Ronald D. Massari, M.D.

Benjamin Fusman, M.D.

Stuart E. Shulruff, M.D.

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