Atlantic Cardiology, L.L.C.

KENNETH B. HARRIS, M.D., FACC
M. SHAHID, M.D.
NIDHI TRIPATHI, M.D.
EDWARD J. CHOI, M.D., FACC
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HERITAGE COMMONS
444 NEPTUNE BOULEVARD
NEPTUNE, NJ 07753
TELEPHONE: (732) 775-5300
FAX: (732) 988-9080

MERIDIAN HEALTH VILLAGE AT JACKSON
27 SOUTH COOKS BRIDGE ROAD
JACKSON, NJ 08527
TELEPHONE: (848) 217-3010
FAX: (732) 928-5382

THE GRANGE
22 NORTH MAIN STREET
MARLBORO, NJ 07746
TELEPHONE: (732) 462-6666
FAX: (732) 462-8804

PATIENT REGISTRATION

PLEASE PRINT IN BLACK INK CAPITALS ONLY

PLEASE FILL OUT BOTH SIDES

Date_____

Marital Status (x one)
S__ M___ Sep.___ D___ W____

This section refers to PATIENT ONLY

NAME_____

BIRTHDATE ___/___/___ SS#____/____/_____

ADDRESS_____

CITY_____STATE____ZIP_____

SEX _____ AGE_____

HOME PHONE ( )_____

CELL PHONE ( )_____

WORK PHONE ( )_____

EMPLOYER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

OCCUPATION_____

IS THIS JOB RELATED ☐ Yes ☐ No If yes, date_____

IS THIS MOTOR VEHICLE RELATED? ☐ Yes ☐ No

IF YES, DATE OF ACCIDENT_____

This section refers to SPOUSE or DEPENDENT or SIGNIFICANT OTHER

NAME_____

ADDRESS_____

CITY_____STATE____ZIP_____

CELL PHONE ( )_____

HOME PHONE ( )_____

WORK PHONE ( )_____

BIRTHDATE ___/___/___ SS#____/____/_____

RELATIONSHIP TO PATIENT_____

OCCUPATION_____

EMPLOYER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

CHECK (ONE) ☐ SPOUSE ☐ PARENT
☐ RELATIVE ☐ CARE GIVER ☐ SIGNIFICANT OTHER

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for both carriers. Please list all numbers on your card(s). If you have a 3rd insurance please advise receptionist.

Primary Insurance Name_____

Address_____

_____

Phone #_____

Policy Holder/Subscriber

Name_____

Relationship of Patient to Subscriber

Self_____ Spouse_____Child_____Other_____

Insured ID No._____

Group No. & Company Name_____

Policy Holder's Birth Date_____

Secondary Insurance Name_____

Address_____

_____

Phone #_____

Policy Holder/Subscriber

Name_____

Relationship of Patient to Subscriber

Self_____ Spouse_____Child_____Other_____

Insured ID No._____

Group No. & Company Name_____

Policy Holder's Birth Date_____

*** Contact in case of emergency (someone not residing with you):**

Name:_____ **Address:**_____

Phone:_____ **Relationship**_____

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I AM FINANCIALLY RESPONSIBLE for any balance not covered by my insurance carrier. In the event my account is placed for collection with an attorney or agency. I will pay collection fees (33 1/3% of balance)
A copy of this signature is valid as the original.

Signature X_____

1/12 (TURN OVER)

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Patient's Name_____ **Date**_____

E-Mail address_____

What is the best way for us to contact you?

- ☐ home phone
- ☐ cell phone
- ☐ business phone

Do you have a living will?

- ☐ yes
- ☐ no

To comply with federal regulations, we are required to ask you to fill out the following items:

Race

- ☐ White
- ☐ African American
- ☐ Asian
- ☐ More than one Race
- ☐ other_____
- ☐ Prefer not to disclose

Ethnicity

do you consider yourself

Hispanic / Latino

- ☐ yes ☐ no
- ☐ Prefer not to disclose

Preferred Language (if other than English)_____

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Welcome to Atlantic Cardiology

Our offices have a long standing reputation for the caring and sensitive treatment of our patients and their families. We are committed to giving you the best care possible. Here is a summary of our financial policies.

Please take the time to read this thoroughly.

Insurance Billing

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Your insurance policy is a contract between you and your insurance company. Failure to comply with your insurance company requirements may result in lower or no payment.
PLEASE REMEMBER THAT YOU ARE RESPONSIBLE TO KNOW YOUR INSURANCE BENEFITS.

1. Co-Pays – a re due at the time of your visit. This is the rule of your insurance company. If you are unable to pay your co -pay at the time of your visit we will reschedule your appointment for the next available office time.
2. Referrals – if required by your insurance company you must have your referral at the time of your visit. If you do not have your referral we will reschedule your appointment for the next available office time.
3. Medicare – we participate with Medicare. We will file to Medicare and your secondary/supplemental plan You will be responsible for any balance due to deductibles, co-insurances, or co-pay that is determined by your plans. If you do not have a secondary/supplemental plan we require the Medicare 20% co-insurance to be paid at the time of visit.
4. In Network Insurance – we will file to your insurance company first. You will be responsible for any balance due to a deductible, co-insurance or co-pay that is determined by your plan. If we do not have a response from your insurance company within 45 days you will be responsible for the balance.
5. Out of Network / Self Pay – Payment in full is due upon completion of the visit. As a courtesy we will file to your out of network insurance for your reimbursement.

Charges / Fees

Appointments– $25.00 service fee will be due if you miss an appointment or do not give the proper notice. W e require 24 hour notice for cancellation and rescheduling of appointments.

Late fee / Collection – $10.00 late fee will be added to your bill if a payment or payment arrangement is not made within 30 days. If you have not made any payments or payment arrangements within 90 days your account will be considered seriously delinquent and will be forwarded to our outside collection agency.

Returned Checks – $20.00 service charge will be added to your bill if a check is returned to us by your bank.

Disability Forms– $10.00 service charge is due for each Disability, Medical Leave, or Supplemental Insurance form filled out. (Not applicable for New Jersey State Disability Forms)

Our office accepts cash, checks, and credit card payments for your convenience. Our office is here to help you. If you have any questions regarding our financial policies please do no hesitate to contact us.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF THE ABOVE FINANCIAL POLICY.
A COPY IS AVAILABLE UPON REQUEST. THANK YOU FOR YOUR COOPERATION.

PRINT PATIENT NAME X _____

SIGN PATIENT NAME X _____ DATE _____

CONSENT TO USE ELECTRONIC COMMUNICATION

Atlantic Cardiology, LLC offers electronic communication. This includes but not limited to texting, email, automated phone calls and the Patient Portal. These services are only for patients of Atlantic Cardiology, LLC. All users must be established by an office visit.

WE DO NOT GIVE ANY EMERGENCY SERVICES BY ELECTRONIC COMMUNICATION

If you have an emergency, call Atlantic Cardiology and/or call 911. For questions about electronic communication, call us at 732-775-5300.

All electronic communication is kept in your medical record. Atlantic Cardiology clinical team along with your doctor may send or get your messages. Examples of how Atlantic Cardiology uses electronic communication:

Texts, emails, and phone calls

a) Appointment reminders.

Patient Portal

a) Internet access to your medical information.
b) Messages to your doctor.
c) Request for an appointment
d) Medication refills.
e) Review lab results.
f) Get a referral.

The electronic services are not used for:

a) Giving medical advice.
b) Prescribing new medicine.
c) Selling any information.

Risks of using electronic communication include but are not limited to:

- Unauthorized access. You must protect your cell phone and/or user name or password.
- Unauthorized access by illegal means such as "hacking." Even if you protect user name and password, others might be able to access info by guessing.
- Atlantic Cardiology is not responsible for messages sent in error

PATIENT ACNOWLEGEMENT AND AGREEMENT TO ELECTRONIC COMMUNICATION

I have read and fully understand this consent form. I understand the risks and consent to the terms.

I agree to follow the rules of the electronic communication services. I understand the misuse or failure to follow the rules of the electronic communication may lead in stopping of access.

I understand that access to these electronic communication services (texts, email, Patient Portal, etc.) is my choice. I can "opt-out" of these services at any time by e-mailing Atlantic Cardiology at optout@atlanticcardiology.com

I also understand that Atlantic Cardiology may stop this service at any time and for any reason.

I have read the consent form and the above information. I accept the terms.

I agree to the following electronic services:

_____ Email Alerts

_____ Automated Phone Calls

_____ Patient Portal

_____ Text messages

Signature_____

Date_____

Date Consent Given:_____

Patient Initials_____

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Due to recent changes in the healthcare insurance industry
We are required to have you sign and date this form.

It is the patient's responsibility to know their exact insurance coverage. In the event you fail to notify us about any changes in your insurance coverage, any charges or future scheduled procedures from today's visit that are denied for inaccurate insurance information provided by the patient will become the patient's responsibility.

_____

Patient Name

_____

Patient Signature

_____

Patient date of Birth

_____

Date

Change in Insurance

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YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

Communications: You may request our practice communication with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

Requesting restrictions in disclosure: You may request that we have restriction in our use or disclosure of your medical information, for treatment, payment or healthcare operations, Additionally, you have the right to request that we restrict our disclosure of your medical information to only certain individuals involved in your care or the payment of your care, such as family members or friends. We are required to agree to your request; however, if we do agree, we are bound by our agreement, except when otherwise required by law, n emergencies, or when the information is necessary to treat you.

Atlantic Cardiology, is participating in a Health Information Exchange (HIE) program to improve your quality of car by allowing us to share your health information. If you do not want to have our information shared, please notify us in writing.

Obtaining copies of medical information: You have the right to inspect and obtain a copy of the medical information that may be used to make decisions about your care, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request to Atlantic Cardiology - Compliance Office, at our address.

Amending your records: You may ask to amend your health information if you believe it is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. Please submit your request in writing to the appropriate address above.

Right to a copy of this notice: You are entitled to a copy of this Notice of Privacy Practice. You may ask us to give you a copy of the Notice at any time. To obtain a copy, contact our front desk receptionist.

Right to file a complaint: If you beleive that your privacy right have been violated, you may file a complaint with the practice, or with the Secretary of the Department of health and Human Services. To file a complaint, contact Atlantic Cardiology at the appropriate address above. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice.

I hereby acknowledge that I have been presented with a copy of the Atlantic Cardiology Notice of Privacy Practice. I understand that this document is a condensed version of the full policy and I understand that I may request an unedited copy of the full text of the Notice of Privacy Policy at any time.

Name (please print): _____

Signature: _____

Please only disclose personal medical information to the following person(s): _____

_____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or wad not medically necessary. This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under health benefits+plan issued in New jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance. (DOBI) using an Independent Utilization Review Organization (URO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking a ✓ or an X and signing below, agree below, agree to:

❑ representation by _____ in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-1. 1. The release of personal health information to DOBI, its contractors for the Independent Health care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires 24 months, but I may revoke both sooner.

❑ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID # _____ Date: _____

Relationship to Patient: ❑ I am Patient ❑ I am the Personal Representative (provide contact information on back)

If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the parent may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides of this form

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If you have an emergency, call Atlantic cardiology and/or 911. For questions about electronic communication, call us at 732-775-5300.

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Texts, e-mails, and phone calls

a) Internet access to your medical information.
b) Messages to your doctor.
c) Request for an appointment.
d) Medication refills.
e) Review lab results.
f) Get a referral.

The electronic services are not used for:

a) Giving medical advice.
b) Prescribing new medication.
c) Selling any information.

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- Unauthorized access. You must protect your cell phone and/or user name or password.
- Unauthorized access by illegal means such as "hacking'. Even if you protect user name and password, others might be able to access info by guessing.
- Atlantic Cardiology is not responsible for messages sent in error.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT TO ELECTRONIC COMMUNICATION

I have read and fully understand this consent form. I understand the risks and consent to the terms.

I agree to follow the rules of the electronic communication services. i understand the misuse or failure to follow rules of the electronic communication may lead to stopping of access.

I understand that access to these electronic communications services (texts, e-mail, Patient Portal, etc.) is my choice. I can stop "opt-out" of these services at any time by e-mailing Atlanyic Cardiology at optout@atlanticcardiology.com.

Print Name _____

Signature _____

E-mail address _____

PATIENT NAME _____ DATE _____ REFERRED BY _____

Your Primary Care Physician _____ Phone # _____

Your Cardiologist _____ Phone # _____

BRIEFLY DESCRIBE REASON FOR YOUR VISIT _____

Medical History	yes	no
diabetes	☐	☐
high blood pressure	☐	☐
sleep apnea (c-pap)	☐	☐
seizures	☐	☐
pneumonia	☐	☐
asthma	☐	☐
tuberculosis	☐	☐
emphysema	☐	☐
kidney disease	☐	☐
hepatitis	☐	☐
liver disease	☐	☐
stomach ulcers	☐	☐
arthritis	☐	☐
gout	☐	☐
anemia	☐	☐
thyroid	☐	☐
phlebitis	☐	☐
HIV	☐	☐
diverticulitis	☐	☐
colon cancer	☐	☐
gyn cancer - site _____	☐	☐
melanoma - site _____	☐	☐
other cancer - site _____	☐	☐
	☐	☐

Any other information you feel may be important to the doctor _____

Surgical History	yes	no
gallbladder	☐	☐
appendectomy	☐	☐
hernia repair	☐	☐
hemorrhoidectomy	☐	☐
colon surgery	☐	☐
orthopedic surgery	☐	☐

If yes, body part _____

Titanium or Metal

Other surgery _____

Cardiac History	yes	no	year
cardiac surgery	☐	☐	_____
type			_____
pacemaker	☐	☐	_____
defibrillator	☐	☐	_____
stents	☐	☐	_____
heart attack	☐	☐	_____
heart valve disease	☐	☐	_____
irregular heartbeat	☐	☐	_____
stroke	☐	☐	_____

Social History	yes	no	If yes, amount
cigarette smoking	☐	☐	_____
cigar or pipe smoking	☐	☐	_____
alcohol use	☐	☐	_____

Female Patients please answer the following:

Date of last menstrual period _____

Date of last breast exam by a physician _____

Date of last mammogram _____

Age of first menstrual period _____

	yes	no
Personal history of breast cancer	☐	☐
Previous breast surgery:	☐	☐
biopsy	☐	☐
lumpectomy	☐	☐
mastectomy	☐	☐
implants	☐	☐

other _____

Family History	yes	no	Relative
diabetes	☐	☐	_____
heart disease	☐	☐	_____
colon cancer	☐	☐	_____
ovarian cancer	☐	☐	_____
breast cancer	☐	☐	_____

other _____

Please check yes or no for each of the following if you have experienced within the last 2 months

	yes	no		yes	no		yes	no
unexplained weight loss	☐	☐	chest pain	☐	☐	excessive gas	☐	☐
change in a skin lesion	☐	☐	ankle swelling	☐	☐	hemorrhoids	☐	☐
persistent headache	☐	☐	palpitations	☐	☐	indigestion	☐	☐
nosebleeds	☐	☐	difficulty urinating	☐	☐	jaundice	☐	☐
neck pain	☐	☐	blood in urine	☐	☐	nausea	☐	☐
chronic cough	☐	☐	black or tarry stool	☐	☐	vomiting	☐	☐
wheezing	☐	☐	blood in stool	☐	☐	dizziness	☐	☐
breast mass	☐	☐	constipation	☐	☐	easy bruising	☐	☐
nipple discharge	☐	☐	diarrhea	☐	☐	back pain	☐	☐

Immunizations up to date? yes☐ no☐ **Foreign travel within last year?** yes☐ no☐

Pnuemovax? yes☐ no☐ date _____ **Pregnancy History / number of pregnancies** _____

Colonoscopy last 5 years yes☐ no☐ **number of live births** _____

1/12