CARDIOLOGY SOLUTIONS, PLLC

Physician you are seeing:	**Appointment date**:

PATIENT INFORMATION

Last name:	**First**:	**Middle Initial**:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	**Birth Date**:	**Sex**: ❑ M ❑ F
Street Address/PO Box:	**City**:	**State & Zip Code**:
Email address:		**Social Security#:**
Cell/Mobile phone: ( )	**Home Phone**: ( )	**Work Phone**: ( ) **Ext**:
Employer Name:	**Employer Address**:	**Occupation**:
***Pharmacy Name**:	**Pharmacy Address**:	
Pharmacy Phone: ( )	**Pharmacy Fax**: ( )	

REFFERAL SOURCE

Referring Source (Please check all that apply): ❑ Physician/Clinic ❑ Family/friend ❑ Clergy ❑ Employer/Coworker
❑ Insurance ❑ No Referring MD ❑Self ❑ **Other**:

Referring Physician's Name:	
Referring Physician's E-mail:	
Referring Physician's Address:	
Referring Physician's Phone: ( )	**Referring Physician's Fax**: ( )

OTHER TREATING PHYSICIANS

Primary Care Physician:	
Address:	Phone: ( )
Fax: ( )	
Specialist Physician(s):	
Physician Name:	Address:
Phone: ( )	Fax: ( )
Physician Name:	Address:
Phone: ( )	Fax: ( )

INSURANCE INFORMATION

Person responsible for bill: ❑ Self	**Birth Date**: / /	**Address** (if different):	**Home Phone**: ( )
Occupation:	**Employer**:	**Employer Address**:	**Employer Phone**: ( )
Name of primary insurance:			
Subscriber's Name: ❑ Self	**Birth Date**:	**Group #**:	**Policy #**:
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child	❑ Other	

SECONDARY INSURANCE (IF APPLICABLE)

Name of secondary insurance:	**Subscriber's Name**:	**Group #**:	**Policy #**:

CARDIOLOGY SOLUTIONS, PLLC

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY		
Please notify in case of emergency:	**Relationship to Patient**:	
❑ Check if address is the ***same*** as in patient information		
Address:	**City, State**:	**Zip**:
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, (see financial agreement). I also authorize ***Cardiology Solutions*** and/or insurance company to release any information required to process my claims**.**

Patient/Guardian signature:	**Date**:

Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

CARDIOLOGY SOLUTIONS, PLLC

Name: _____

Date of Birth: _____

MRN: _____

Date of Service: _____

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Dr(s). _____(the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company; or if I fail to provide the required referrals (as appropriate), I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I (as the guarantor) agree to immediately pay all amounts not covered by insurance (deductibles, copays, coinsurance or any other non-covered items for which I may be responsible). If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Cardiology Solutions immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician(s) to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the Provider (s) and/or organizations providing the service(s).

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website or can be provided to me upon request.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in which the Physicians provide services, even though the Physicians may be affiliated with those hospitals or facilities. I understand that I can determine the health plans participated in by physicians who are employed by, contracted by, or are affiliated with Cardiology Solutions facilities services asking a representative. I also understand that I can also determine the health plans accepted by hospitals and facilities of Cardiology Solutions by asking a representative.

I understand that laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services provided in connection with my care may not be billed by the Physicians, and may be billed separately by the laboratories/facilities/providers who provide those services. I further understand that laboratories/facilities/providers who provide laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services may or may not be participating providers in my health care plan network, that I can obtain the contact information for any such laboratories/facilities/providers whose services may be needed in connection with my care from the Physicians, and that I can contact those laboratories/facilities/providers directly to obtain information regarding their health plan participation.

I understand that if I elect or choose to obtain services from a provider who I know or who has been disclosed (in writing, on a website, and/or at the time my appointment was made) as not participating in my health plan network, I will be responsible for any and all charges billed by that provider to me. I further understand that if the Physicians do not participate in or with my health plan and/or network, the amount or estimated amount that the Physicians will bill for healthcare services can be made available to me in advance, upon request.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

Cardiology Solutions, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information

_____
Patient Name

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ *The patient refused to sign despite good faith efforts*
- ☐ *The patient was unaccompanied and not alert and oriented*
- ☐ *The patient was unaccompanied and needed emergency care*
- ☐ *Other,(explain)*: _____

Employee Signature:_____Employee Title: _____

Print Name:_____ Date: _____

- ☐ Acknowledgement subsequently obtained, (see above).