



PATIENT REGISTRATION

Date: _____

Referring MD: _____

Primary Physician: _____

Patient Name: _____
First Name Initial Last Name

Birthdate: ____/____/____ Sex: _____
Social Security #: _____-_____-_____
Marital Status: S___ M___ Sep___ D___ W___

Mailing Address: _____

City: _____ State: _____ Zip: _____

*Please indicate preferred method for contact
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email Address _____

Occupation: _____

Employer: _____

Employer Address: _____

To comply with Federal regulations, we are required to ask you to fill out the following

Is this visit job related? Yes No If yes date _____
Is this Motor Vehicle Related? Yes No
If yes, date of accident _____

Race Ethnicity
White Hispanic or latino
Black/African American Prefer not to disclose
Asian
American Indian/Pacific Native
Native Hawaiian/Alaskan Native
Other: _____
Prefer not to disclose

Are you currently: In a Rehab Facility
 In a Skilled Nursing Facility
 In an Assisted Living
 In a Hospice Program
 Not applicable

If yes please provide:
Facility Name: _____

Alternative Address: _____

Primary Language: _____

Please provide all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, please supply information for both.

Primary Insurance: _____
ID # _____
Group # _____
Subscriber Name _____
Relationship to Subscriber
Self___ Spouse___ Child___ Other___
Subscriber Birthdate: _____

Secondary Insurance: _____
ID # _____
Group # _____
Subscriber Name _____
Relationship to subscriber
Self___ Spouse___ Child___ Other___
Subscriber Birthdate: _____

Assignment of Insurance Benefits: I request that payment of authorized benefits be made on my behalf by any Insurance Company involved in my benefits, Medicare or Medicaid to Shore Heart Group, PA. I authorize release of medical information to Medicare (HCFA), Medicaid, or any insurance involved in my benefits.

Patient Signature: _____ Date: _____

SHORE HEART GROUP, P.A.

Patient Name (please print)

Date of Birth

Patient Acknowledgement and Consent for Use and Disclosure of Protected Health Information

I acknowledge receipt of a Notice of Privacy Practices from Shore Heart Group, PA.

With my consent, Shore Heart Group, P.A. may use and disclose protected health information about me to provide treatment, for payment or healthcare operations. The complete information can be found in the accompanied Shore Heart Group, P.A Notice of Privacy Practices.

With my consent, Shore Heart Group, P.A. may call my home or other chosen location and leave a message on voice mail or with a designated person in reference to any items that assist the practice carrying out the provision of treatment, for payment or healthcare operations. For example, this would pertain to appointment confirmations and obtaining payment for care provided; and may be related to my clinical care, including laboratory and test results.

With my consent, Shore Heart Group, P.A. can mail to my home or other designated location any items that assist the practice in carrying out my medical care, payment or healthcare operations, such as appointment reminders and patient statements.

In accordance with Federal and HIPAA regulations, I hereby give my consent for Shore Heart Group, P.A. to release PHI about me to the following person (s):

Name

Relationship

___ I do not wish to have any of my health-related information released to anyone other than myself.

I have a right to review the Notice of Privacy Practices prior to signing this consent. I may revoke my consent in writing, except to the extent that the practice already made disclosures regarding me based on my prior consent.

Signature of Patient or Legal Representative

Date



Michael Aaron, D.O., FACC, FASN
 Maurice Weiss, M.D., FACC, FSCAI
 Ihab Girgis, M.D., FACC, FACP, FHRS
 Tony N.T. Chu, M.D., FACC, FSCAI
 Leonard Sandler, M.D., FACC
 James Orlando, M.D., FACC, FSCAI
 David Pinnelas, M.D., FACC, FSCAI
 Renato Apolito, M.D., FACC, FSCAI
 Rayson Yang, M.D., FACC, FSCAI

Riple Hansalia, M.D.
 Marcus Hanfling, D.O., FACC
 Edmund T. Karam, M.D., FACC, FHRS
 Jasrai S. Gill, M.D.
 Dale Edlin, M.D., FACC
 Julie Master, D.O., FACC
 Arthur Okere, M.D., FACC
 Ravi Diwan, M.D.
 Haroon Khan, PA-C, CCDS, CEPS

INSURANCE AND BILLING POLICIES

INSURANCE: Shore Heart Group will gladly submit claims to participating insurance carriers. In order to do so, we need your cooperation. Complete and current insurance information is required in order for our office to submit a claim to your primary insurance plan. This information needs to be provided at **EACH** visit or you may be required to reschedule or make payment at the time of service. It is the patient’s responsibility to notify Shore Heart Group of any change in or termination of their insurance. If using a parent’s insurance, the parent must sign accepting financial responsibility if not covered.

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

CO-PAYS, CO-INSURANCE AND DEDUCTIBLE: Co-pays are the fixed amount that your insurance plan has designated as your responsibility for each office visit. This amount will be collected prior to your office visit. If a coinsurance or deductible is applied to 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 payment is not received within 60 days, you will be billed for the amount owed as per Medicare. 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 ACCIDENT: 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, whether provided in our office, hospital, or at a radiology facility. Patients should know their 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 present for testing at an outside hospital or facility without obtaining the correct authorizations or referrals, they may bill you for the services rendered.

CANCELLATION POLICY: If you fail to call and cancel your appointment 24 hours prior, we reserve the right to bill you a cancellation fee of \$20.00 and the cost of radiopharmaceuticals for nuclear imaging studies (approx. \$120.00). These charges are not billed to insurance and will be your responsibility.

RETURNED CHECKS: If a check you issued as payment is returned by your bank (for any reason), you will be charged a fee of \$20.00. 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 Heart Group, PA. my failure to fulfill my financial obligations may cause interruptions or delays in my care.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____

1820 Route 33 · Suite 4B · Neptune, NJ 07753 · (732) 776-8500 · Fax (732) 776-8946
 35 Beaverson Boulevard · Unit 9B · Brick, NJ 08723 · (732) 262-4262 · Fax (732) 262-4317
 9 Mule Road · Unit E1 · Toms River, NJ 08755 · (732) 281-1101 · Fax (732) 281-1105
 115 East Bay Avenue · Manahawkin, NJ 08050 · (609) 971-3300 · Fax (609) 597-4656
 901 W. Main Street · Suite 107 · Freehold, NJ 07728 · (732) 308-0774 · Fax (732) 308-0355
 179 Avenue at the Common, Suite 101, Shrewsbury, NJ 07702 · (732) 542-7600 · Fax (732) 542-7655
 1 State Highway 35 South · Keyport, NJ 07735 (732) 360-6333 · Fax (732) 542-7655

SHORE HEART GROUP: CONSENT TO ARBITRATION

AGREEMENT TO ARBITRATE: IT HAS BEEN FULLY EXPLAINED TO ME AND I UNDERSTAND THAT THERE ARE INHERENT RISKS AND DANGERS ASSOCIATED WITH ANY MEDICAL PROCEDURE OR TREATMENT. IT IS MY INTENTION BY SIGNING CONSENT TO HAVE ANY DISPUTE RELATED TO AND/OR ARISING OUT OF ANY TREATMENT, MEDICAL PROCEDURES, SURGERIES, AND/OR DIAGNOSTIC PROCEDURES OR THERAPIES PROVIDED BY THIS OFFICE INCLUDING ANY CLAIMS OF MEDICAL MALPRACTICE (WHICH WOULD INCLUDE ANY CLAIMS REGARDING PROCEDURES CLAIMED BY ME TO BE NEGLIGENTLY PERFORMED) WILL BE SUBMITTED TO BINDING ARBITRATION. BY ENTERING INTO THIS AGREEMENT, I AGREE TO BE BOUND BY THE ARBITRATION PROCEDURE AND PROCESS AND KNOWINGLY INTEND TO UTILIZE THIS METHOD FOR ANY RESOLUTION. BY DOING SO, I AGREE TO CONSCIOUSLY FORGO A JURY TRIAL. I AGREE TO ARBITRATE ANY AND ALL CLAIMS THAT MAY ARISE IN CONNECTION WITH MY MEDICAL TREATMENT AND/OR SERVICES PROVIDED BY THIS OFFICE INCLUDING ANY CLAIM FOR MEDICAL MALPRACTICE. THIS INCLUDES ANY SPOUSE, LEGAL PARTNER, CHILDREN, GUARDIAN, PARENT, ECT. THE PARTIES AGREE THAT THE DECISION AND AWARD OF THE ARBITRATOR SHALL BE FINAL AND CONCLUSIVE UPON THE PARTIES, IN LIEU OF ALL OTHER LEGAL PROCEEDING. IN THE EVENT THAT THE MEDICAL GROUP, DOES NOT RECEIVE PAYMENT FOR SERVICES RENDERED, IT IS SPECIFICALLY UNDERSTOOD THAT THIS AGREEMENT SHALL NOT WAIVE THE MEDICAL GROUP'S RIGHT TO UTILIZE THE COURT SYSTEM TO COLLECT FEES, INTEREST AND COURT COSTS FOR SERVICES RENDERED. I UNDERSTAND THAT SHOULD I NOT AGREE TO ARBITRATION, I HAVE THE RIGHT TO SEEK MEDICAL CARE FROM SOME OTHER PHYSICIAN OR MEDICAL GROUP.

Print Name

Patient Name

Date

Power of Attorney, if applicable

Date

SHORE HEART GROUP, PA

Date: _____

LAST NAME: _____ FIRST NAME: _____ AGE: _____

REFERRING PHYSICIAN: _____ Height: _____ Weight: _____

What is the problem you have been having?

ALLERGIES: _____ Recent testing done? _____

Have you ever had a heart catheterization? _____ Angioplasty? _____ Bypass Surgery? _____

Previous echocardiogram? _____ Previous carotid ultrasound: _____ Previous stress test: _____

MEDICATIONS: Please list ALL medications, prescription or non-prescription, which you are "CURRENTLY" taking and include how many times per day you are taking them and the strength:

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

Do you take aspirin or other Blood thinners? _____ Herbal medications? _____ Vitamins? _____

PAST MEDICAL HISTORY: Hospitalization or Operations?

Year	Reason for Hospitalization	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEM: Do you have any of the following? Yes or No

- | | | |
|------------------------------------|---------------------------|--------------------------|
| Heart Problems: _____ | Asthma: _____ | Kidney Problems: _____ |
| Murmur/Valve Problem: _____ | COPD: _____ | Bladder Problems: _____ |
| High Blood Pressure: _____ | Emphysema: _____ | Prostate Problems: _____ |
| Irregular Heart Beat: _____ | Breathing Problems: _____ | Seizure Disorders: _____ |
| Chest Pain: _____ | Anemia: _____ | Arthritis: _____ |
| CVA, TIA: _____ | Thyroid Problems? _____ | Stomach Problems: _____ |
| Peripheral Vascular Disease: _____ | | |

Please list any other Medical Conditions: _____

FAMILY HISTORY: Any immediate family members have a history of the following?

- | | | | |
|----------------------|----------------------------|------------------------|----------------------------|
| Diabetes: _____ | High Blood Pressure: _____ | Cancer: _____ | Anemia: _____ |
| Asthma: _____ | High Cholesterol: _____ | Arthritis: _____ | Thyroid Problems: _____ |
| Heart Disease: _____ | Stroke: _____ | Kidney Problems: _____ | Pancreatic Problems: _____ |

SOCIAL HISTORY:

- Occupation: _____ Marital Status: _____ Children (ages): _____
- Do you smoke?: _____ If yes how much?: _____ Do you drink coffee, tea? _____ Cups per day? _____
- Do you drink alcohol? _____ If yes how much? _____ Do you experience high anxiety? _____
- Do you follow a special diet? _____

FOR STAFF USE

- Recent Testing Results Received _____
- Medical Records Release Received _____
- Hospitalization Records Received _____