PATIENT REGISTRATION

Date:_____

Referring MD:_____

Primary Physician:_____

Patient Name:_____
First Name Initial Last Name

Mailing Address:_____

City:_____ State:_____ Zip:_____

Occupation:_____

Employer:_____

Employer Address:_____

Is this visit job related? □Yes □No If yes date__ ___
Is this Motor Vehicle Related? □Yes □No
If yes, date of accident_____

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:_____

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

*Please indicate preferred method for contact
___Home Phone:_____
___Cell Phone:_____
___Work Phone:_____

___Email Address_____

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

Race
□White
□Black/African American
□Asian
□American Indian/Pacific Native
□Native Hawaiian/Alaskan Native
□Other:_____
□Prefer not to disclose

Ethnicity
□Hispanic or latino
□Prefer not to disclose

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. nay 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.

REFFERALS/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 y our insurance processes the claim.

MEDICARE: Our doctors are participating with Medicare Part B and we will bill for serviced 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 PLOICY: 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:_____

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 THIS 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 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, ETC. 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 PROCEEDINGS. 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 Signature Date

_____ _____
Power of Attorney, if applicable Date

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 Highway 35 South, Keyport, NJ 07735· (732) 360-6333 · Fax (732) 542-7655