PATIENT REGISTRATION

DATE:_____________________

Patient Name:_________________________________
First Name Initial Last Name

Mailing Address:______________________________

City:______________________ State:_____________

Zip:_____________ Language (Optional)___________

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:____________________________

Primary Care Physician:__________________________

Referring Doctor________________________________

Birth Date: ______/______/______ Age:__________
Social Security #: _________-_______-___________
Marital Status:____________ Sex:______________

*Please indicate preferred method for contact
___Home Phone:____________________________
___Cell Phone:_____________________________
___Work Phone:____________________________
___Email Address___________________________

Pharmacy Name:___________________________

Pharmacy Phone Number:____________________

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

Race(Optional)
□White
□Black/African American
□Asian
□American Indian/Pacific Native
□Native Hawaiian/Alaskan Native
□Other:_____________________
□Prefer not to disclose

Ethnicity(Optional)
□Hispanic or latino
□Prefer not to disclose

Emergency Contact:__________________________

Relationship to Patient:________________________

Phone Number:______________________________

Address:___________________________________

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:_________________
Subscriber Birth Date:______________________

Secondary Insurance:________________________
ID #______________________________________
Group #____________________________________
Subscriber Name____________________________
Relationship to subscriber:____________________
Subscriber Birth Date:_______________________

______________________________ ______________________________

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

1820 State 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
555 Iron Bridge Road Suite 15, Freehold, NJ 07728 (732) 308-0774 Fax (732) 333-1366
160 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) 888-8225

Patient Name: ___________________

Dear Patient,

We are committed to providing the best possible care in every aspect of your experience. To achieve this goal, your clear understanding of our Patient Financial Policy is an important aspect of this relationship.
Your insurance is a contract between you and your insurance company. It is impossible for us to be knowledgeable about every patient's specific plan coverages and limitations. Please bring your insurance card(s) with you to every visit and notify us of any changes in your insurance. If you are having testing done, don't assume you only have a co-pay, as most insurances will apply deductibles and co-insurances for testing. If you need to know your responsibility for a service, reach out to your insurance company. We will not know your responsibility until after the insurance company has processed your claims.

Insurance Coverage: You will be financially responsible for any and all charges for professional services. Exceptions are when patient responsibility is limited by statutory regulation (such as Medicare, Medicaid, Managed Care Contracts (HMO, PPO, etc.), authorized Workers' Compensation, or Motor Vehicle carriers. In cases of claims being submitted to your insurance carrier, it is your responsibility to financially cover any deductibles, co-payments and non-covered-services as stipulated by your specific insurance plan. Co-insurances and copays are due at the time of service. Any payment/explanation of benefits issued directly to you for care received from SHG must be forwarded to SHG in a timely fashion for posting of payment and/or appropriate adjustment. Failure to provide accurate insurance information may result in you being responsible for the entire bill.
Referrals/ Authorizations: Proof of your insurance coverage must be provided at the time of service, along with any necessary authorizations/referrals. All associated co-payments will be collected at the time of your office visit. If your insurance company requires a referral or pre-authorization you are responsible for obtaining it or you may be responsible for payment or need to reschedule your appointment.
Medicare: If you have Medicare, please note that although we participate with and accept assignment with Medicare, you are still responsible for your deductible and coinsurance. If you have a secondary insurance with which we participate, and you have given us all the required information, we will also bill them. Deductibles, co-insurances and co-pays for secondary insurances are due at the time of service.
If payment is not received by your secondary insurance carrier within 60 days, you may be billed for the amount owed as per the Medicare explanation of benefits.
Disability Forms/Reports: Requests for completion of disability forms, reports or other paperwork will require an advance fee based on the complexity of the form. Please allow 5 business days for completion.
Release of Medical Records and Fees: Medical record copies and imaging will require written authorization and pre-paid fees related to preparation. Whenever possible, records going directly to the patient will be provided through the patient portal to reduce costs to the patient. Copying fees in accordance with (N.J.A.C. 13:35-6.5© (4) shall not exceed $1.00 per page or $100 for the first 100 pages. For medical records that contain more than 100 pages, a copying fee of no more than $0.25 per page will be charged thereafter, up to a maximum of $200.00 for the entire record. A search fee of no more than $10.00 will also be charged per request. Imaging copies will be $10.00 per CD. Although, we anticipate your copies to be ready within 10 days, NJ law allows 30 days for this process. Requests being made with patient authorization by attorneys, life or disability insurance companies, etc. will be routed to a third party, Med-Request Solutions. They can be reached at 1-800-483-6040.
Medical-Legal Reports/Testimony: The office's policy regarding Medical-legal reports and testimony is that the physicians do not testify, nor make court appearances. Permanency evaluations and narrative reports are prepared at their discretion. If this policy is unacceptable to you or my attorney, please be aware that you should seek cardiovascular care elsewhere.

Patient Name: ___________________

Cost of Collection: Patient balances should be paid in full upon receipt of your statement. If full payment cannot be made, you can contact our office to make payment arrangements with the billing department. It is the patient's responsibility to maintain their account in good standing, regardless of insurance or any other circumstances (such as litigation). If an account is submitted to collections, you will be responsible for all costs associated with collecting owed balances including but not limited to: collection agency, attorney and court fees.
Workers' Compensation and Auto Accidents: It is the patient's responsibility to clearly identify those medical injuries/ conditions which he/she believes are due to a motor vehicle or work related injury at the time of the initial visit on all required documentation. Failure to do so can result in patient liability.
Worker's Compensation Claims: We require written authorization from your employer or its worker's compensation insurance carrier prior to your first visit. Denied charges due to lack of prior authorization will be your responsibility. Your private insurance cannot be used to cover treatment for work injuries unless workers compensation coverage has been denied, does not exist or your case has been settled. Written denial and affidavit is required. [In the event your WC claim is denied after submission, we will bill your regular health insurance carrier only if we are a participating provider and prior authorization was not required.]
Motor Vehicle (PIP) Claims: Injuries involving Motor Vehicle accident/injuries must be submitted to your Motor Vehicle (PIP) carrier and cannot be billed to private insurance unless PIP coverage has been denied, does not exist or private insurance was selected as the primary carrier. You are responsible for any deductible or co-payments under my PIP coverage.
Letter of Protection: If you are being seen for an injury that involves legal action, please be advised that you are still responsible for payment at the time of service. We do not accept letters of protection from attorneys in lieu of payment.
Uninsured: If you do not have insurance, payment is expected in full at the time of service by cash or credit card.
Cancellation Policy: In the event 24 hours' notice is not provided, you will be charged a fee for the missed appointment of $25 for missed office visits and $150 for missed Nuclear Stress or PET tests. These charges are not covered by insurance and will be the patient responsibility.
Return Checks: There will be a $25.00 charge for any check returned unpaid.

- I understand and acknowledge the financial policy and insurance authorization terms stated above.
- **Medicare Assignment of Benefits:** I request that payment of authorized Medicare benefits be made on my behalf to SHORE HEART GROUP, P.A. for any services furnished me by Shore Heart Group, PA. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
- **Assignment of Benefits:** I hereby authorize and instruct any insurance companies involved with my healthcare coverage to make payment directly to SHORE HEART GROUP, P.A. This is for the professional Medical Expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above practice, and I have agreed to pay in current fashion any balance if said professional service charges are over and above this insurance portion of payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to my insurance company, or adjuster involved in the case unless I have made alternative arrangements with respect to this data.

_________________________________ ___________________

Signature of Patient or Responsible Party Date

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

SHORE HEART GROUP, PA

Date:___________________________

LAST NAME:____________________________ FIRST NAME:__________________________ AGE:_______

REFERRING PHYSICIAN:______________________________ Height:_______________ Weight:__________

What is the problem you have been having?____
If your visit is for surgical clearance, what procedures are you scheduled for and please provide the surgeons name above: ______________________ ____
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 ____________________