



NEW YORK CARDIOLOGY ASSOCIATES P.C.

425 E. 61st Street, 6th Floor, New York, NY 10065
Phone: 212-752-2000 | Fax: 212-752-5822

HOLLY S. ANDERSEN, M.D.
FREDERICK J. FEUERBACH, M.D.
HARVEY L. GOLDBERG, M.D.
COLE B. HIRSCHFELD, M.D.
LAWRENCE A. KATZ, M.D.
MARTIN R. POST, M.D.
GERARDO L. ZULLO, M.D.

NEW PATIENT MEDICAL HISTORY

PATIENT INFORMATION

Name _____ Date of Birth _____ Gender _____
Last First Middle Initial MM/DD/YYYY
Primary Phone _____ Email _____ Secondary Phone _____
□ Home / □ Work / □ Cell □ Home / □ Work / □ Cell
Marital Status _____ Occupation _____

DOCTOR / EMERGENCY CONTACT

Referring Doctor _____ Phone Number _____
Primary Care Doctor (if different) _____ Phone Number _____
Emergency Contact _____ Relationship: _____ Cell Phone _____

MEDICAL HISTORY

Have you ever experienced or been diagnosed with any of the following conditions?

- High blood pressure
- Stroke
- Diabetes
- Kidney disease
- Heart murmur
- High cholesterol
- Sleep apnea
- Liver disease
- Angina
- Fainting/Dizziness
- Autoimmune disease
- Thyroid disease
- Heart attack
- Vascular disease
- Lung disease
- Cancer Type
- Irregular heart rhythm
- Aortic aneurysm
- Stomach/intestinal problems
- Other _____

Details on conditions selected above, if needed

Surgical History: please list the name and date of any surgeries you have had

Hospitalizations: please list the date, location, and reason for any prior hospitalizations

Check any vaccinations you have received, including dates if known.

- Influenza _____
- Shingles _____
- Pneumonia _____
- Hepatitis A _____
- Gardasil _____
- COVID-19 _____
- RSV _____
- TDAP (tetanus) _____
- Hepatitis B _____
- Other _____

Do you have known allergies (e.g. medications, foods, latex...)? Yes | No - If yes, list the allergies and what reaction you have had to each.

Do you take any over the counter vitamins or supplements? Yes | No - If yes, write them below.

List all medications you are currently taking.

Medication	Dose	# times/day	Medication	Dose	# times/day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Which of the following screening exams have you had?

	Date	Doctor/Location
<input type="checkbox"/> Colonoscopy	_____	_____
<input type="checkbox"/> Skin exam	_____	_____
<input type="checkbox"/> Eye exam	_____	_____

WOMEN ONLY	Date	Doctor/Location
<input type="checkbox"/> GYN exam	_____	_____
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> Bone density scan	_____	_____

PERSONAL HISTORY

- Yes | No** Do you currently smoke? Cigarettes Pipe Cigars Vaping #daily_____ #years____
- Yes | No** Have you ever smoked? Cigarettes Pipe Cigars Vaping #daily__ #years__ Date stopped _____
- Yes | No** Do you drink alcohol? If yes, # days per week __, # glasses/week of wine __ /beer__ /liquor __
- Yes | No** Do you use any recreational drugs or substances? If yes, please specify: _____
- Yes | No** Do you drink coffee? # cups daily _____
- Yes | No** Do you follow a specific diet? Please specify _____
- Yes | No** Do you exercise regularly? Type and frequency _____

How would you rate your overall level of physical activity? Low Moderate High

How would you rate your overall level of stress? Low Moderate High

How many hours of sleep do you get per night on average? _____

WOMEN ONLY

Pregnancies _____ # Children _____

Were you diagnosed with any of these conditions during any of your pregnancies?

- Gestational hypertension
- Pre-eclampsia/eclampsia
- Gestational diabetes
- Preterm labor

Any other complications of pregnancy?

FAMILY HISTORY

Provide information for **biological relatives only**. If deceased, please list their cause of death, if known.

Father: Alive, age ____ Deceased, age ____ Medical Problems: _____

Mother: Alive, age ____ Deceased, age ____ Medical Problems: _____

Siblings: *(please circle to indicate brother or sister)*

Brother / Sister: Alive, age ____ Deceased, age ____ Medical Problems: _____

Brother / Sister: Alive, age ____ Deceased, age ____ Medical Problems: _____

Brother / Sister: Alive, age ____ Deceased, age ____ Medical Problems: _____

Brother / Sister: Alive, age ____ Deceased, age ____ Medical Problems: _____

Do you have any children? No Yes, # sons ____ # daughters ____

CHIEF COMPLAINT

What symptoms or concerns bring you to the doctor today? Please describe briefly



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FINANCIAL POLICY

Welcome to New York Cardiology Associates, P.C. ! The following is a statement of our financial policy. We hope this gives you a better understanding of our billing practices. Patients cared for by our practice come with different insurance and payment options. Please understand that all the physicians in this practice do not accept the same insurances. It is important that you check with your insurance to verify your benefits, as well as the requirements of your insurance for pre-certifications for diagnostic tests, laboratory and/or pharmacy designations and referrals.

PLEASE REMEMBER TO CHECK OUT AT THE FRONT DESK AFTER YOUR VISIT

Medicare

Our physicians have opted out of the Medicare Program, including Medicare Advantage plans. You will be responsible for payment of all charges at the time of the visit. Due to federal regulations, claims will not be filed to Medicare (or Medicare Advantage plans) and you will receive no reimbursement from Medicare for our services. Supplemental Medicare insurances will also not reimburse you. Additionally, you are required to sign a Medicare Private Contract acknowledging your understanding of this policy.

Managed Care Plans

Some of our physicians are currently participating in a small number of managed care plans. You will be notified if you will be seeing a physician who does not participate with your plan. If you are seeing a physician who participates in plan, your insurance will be accepted as payment in full for covered services and you will be responsible for co-pays, co-insurances and deductibles as dictated by terms of your insurance policy. You are also responsible to notify the practice if your insurance requires a managed care referral, specific pharmacy and/or laboratory designation or pre-certification for procedures. We will verify referrals and pre-certify procedures when you choose an in-network physician.

Out-of-Network Insurances

If your doctor does not have a contractual agreement with your insurance, you will be responsible for payment of all charges at the time of the visit. We will submit a claim on your behalf to your insurance company, and you will be reimbursed by your insurance company based on your out-of-network benefits, if applicable. Some insurances and plans do not permit you to receive reimbursement for services rendered by our out of network physicians.

I understand that Dr. _____ does not participate in my insurance _____ and that I am responsible for all charges.

PAYMENT FOR ALL SERVICES RELATED TO YOUR VISIT IS DUE AT TIME OF SERVICE

The following methods of payment are accepted for your convenience:

- Cash
- Check
- All major Credit cards (Visa, Mastercard, Amex, Discover)

I attest that I have read the above financial policy and I fully understand and agree to its terms.

PATIENT NAME _____ INSURANCE _____

SIGNATURE _____ DATE _____ WITNESS _____



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PATIENT CONSENT FORM

1. I acknowledge that I may request a copy of New York Cardiology Associates' (NYCA) HIPAA Privacy Notice, which describes their obligation to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how NYCA may use and disclose my health information for treatment, payment, and health care operations. I know that I have the right to review NYCA's HIPAA Privacy Notice and to ask questions about it. I understand that NYCA is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

2. I further acknowledge that NYCA can change its HIPAA Privacy Notice in the future and that I can receive a copy of NYCA's current HIPAA Privacy Notice at any time by contacting the Privacy Officer.

3. I understand that I have the right to request that NYCA restrict its uses and disclosures of my health information for treatment, payment, or health care operations. If accepted, these restrictions will be binding on NYCA. However, I understand that NYCA is not required to agree to my requested restrictions.

4. I understand that I have the right to revoke this consent at any time in writing. However, it will not affect any actions NYCA has already taken in compliance with this consent.

5. I know that I have the right to refuse to sign this consent. However, should I refuse, NYCA may refuse to provide me with non-emergency care.

I fully understand and accept decline the terms of this consent.

PRINTED NAME OF PATIENT

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE

PRINTED NAME IF SIGNED ON BEHALF OF PATIENT

RELATIONSHIP TO PATIENT

INITIAL

I do not request any restrictions on NYCA's uses or disclosures of my health information for treatment, payment, or health care operations.



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PREFERRED / IN-NETWORK PHARMACY AND LABORATORY INFORMATION

Patient name: _____ Date of birth: _____

PHARMACY

Our office offers Electronic Prescribing. We request that you list the pharmacy of your choice below. If you use a chain pharmacy, such as Duane Reade or CVS, please include the store number as well as the address and/or phone number. If you use a mail order pharmacy, please indicate which one below.

PHARMACY NAME: _____ STORE#: _____
ADDRESS: _____ PHONE# _____

MAIL ORDER PHARMACY (Please check only one.)

- | | | |
|----------------------------------------------|-------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> EXPRESS SCRIPTS | <input type="checkbox"/> RIGHTSOURCE Rx | <input type="checkbox"/> CVS/CAREMARK MAIL ORDER |
| <input type="checkbox"/> COSTCO MAIL ORDER | <input type="checkbox"/> PRESCRIPTION SOLUTIONS | <input type="checkbox"/> CVS/CAREMARK SPECIALTY |
| <input type="checkbox"/> CIGNA HOME DELIVERY | <input type="checkbox"/> AETNA Rx HOME DELIVERY | <input type="checkbox"/> OTHER: _____ |

LABORATORY SERVICES (Please check only one.)

Lab specimen collected in our office will be sent to Quest Diagnostics. However, certain insurance carriers only cover laboratory services at 100% through a preferred laboratory. If your insurance requires you to utilize a specific laboratory, please indicate below. We strongly urge you to call your insurance carrier before coming in for services to find out which laboratory companies are in-network for your plan.

- LABCORP OTHER: _____

ELECTRONIC HEALTH RECORD

As a component of Electronic Health Record, the government has determined that the following demographics should be included in your patient profile.

Preferred Language

- | | | | | |
|----------------------------------|----------------------------------|---------------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> ENGLISH | <input type="checkbox"/> GERMAN | <input type="checkbox"/> FRENCH | <input type="checkbox"/> SPANISH | <input type="checkbox"/> ITALIAN |
| <input type="checkbox"/> ARABIC | <input type="checkbox"/> CHINESE | <input type="checkbox"/> OTHER: _____ | | |

Race

- | | | | |
|----------------------------------------------------------|--------------------------------------------------------------------|------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> DECLINE | <input type="checkbox"/> ASIAN | <input type="checkbox"/> CAUCASIAN | <input type="checkbox"/> BLACK OR AFRICAN AMERICAN |
| <input type="checkbox"/> AMERICAN INDIAN / ALASKA NATIVE | <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER | | |

Ethnicity (Please check only one.)

- DECLINE HISPANIC OR LATINO NOT HISPANIC OR LATINO OTHER / UNDETERMINED

I attest that the pharmacy and laboratory information provided is true and accurate to the best of my ability. As a component of Electronic Prescribing, we need your consent to access your medication history from your pharmacies. Please sign your name below if you give your consent.

SIGNATURE OF PATIENT

PRINTED NAME OF PATIENT

DATE