# New York Cardiology Associates P.C.

HOLLY S. ANDERSEN, M.D.
FREDERICK J. FEUERBACH, M.D.
HARVEY L. GOLDBERG, M.D.
LAWRENCE A. KATZ, M.D.
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MICHAEL A. ZULLO, M.D.

## DR. ZULLO'S FINANCIAL POLICY

**Welcome to New York Cardiology Associates, P.C.!** The following is a statement of our financial policy. We hope that 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 of 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 current agreement with Medicare is as non-participating providers. You will be responsible for payment of the Medicare Limiting Charges as regulated by NYS at the time of visit for all services, with the exception of laboratory services, flu vaccines, as well as any administered drugs which are mandated as accept assignment. As required, we will submit a claim on your behalf to Medicare and you will be reimbursed by Medicare and your supplemental insurance, if applicable, directly. Such reimbursement may be minus the excess charge and may not equal your payment to us.

**Managed Care Plans**

Some of our physicians are currently participating in some managed care plans. You will be notified if you are seeing a physician who does not participate with your plan. If you are seeing a physician who participates in your managed care 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 your agreement with your insurance company. You are also responsible to notify the practice if your insurance requires a referral, or specific laboratory designation or pre-certification.** We will verify referrals, laboratory designation 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 visit. We will submit a claim on your behalf to your insurance company, and you will be reimbursed by your insurance company based on whether you have out-of-network benefits and the quality of your out-of-network benefits plan. Some insurances and plans do not permit you to receive reimbursement for services rendered by our physicians.

**Our Billing Department is available for any questions or concerns at (212) 752-7550.**

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

**I attest that I have read the financial policy and I fully understand and agree to it.**

**PATIENT NAME:** _____ **INSURANCE:** _____

**SIGNATURE:** _____ **DATE:** _____ **WITNESS:** _____

425 East 61st Street • New York, New York 10065 • Phone: 212.752.2000 • Fax: 212.752.5822

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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 |

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


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NewYork-Presbyterian
The University Hospital of Columbia and Cornell

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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.)

- ☐ **EXPRESS SCRIPTS**
- ☐ **COSTCO MAIL ORDER**
- ☐ **CIGNA HOME DELIVERY**
- ☐ **RIGHTSOURCE Rx**
- ☐ **PRESCRIPTION SOLUTIONS**
- ☐ **AETNA Rx HOME DELIVERY**
- ☐ **CVS/CAREMARK MAIL ORDER**
- ☐ **CVS/CAREMARK SPECIALTY**
- ☐ **OTHER:** _____

**LABORATORY SERVICES** (Please check only one.)

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.

☐ **NEW YORK-PRESBYTERIAN HOSPITAL (NYP)** ☐ **LABCORP** ☐ **QUEST DIAGNOSTICS**

**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**

- ☐ **ENGLISH**
- ☐ **GERMAN**
- ☐ **FRENCH**
- ☐ **SPANISH**
- ☐ **ITALIAN**
- ☐ **ARABIC**
- ☐ **CHINESE**
- ☐ **OTHER:** _____

**Race**

- ☐ **DECLINE**
- ☐ **ASIAN**
- ☐ **CAUCASIAN**
- ☐ **BLACK OR AFRICAN AMERICAN**
- ☐ **AMERICAN INDIAN/ALASKA NATIVE**
- ☐ **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:** _____ **DATE:** _____

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GERARDO L. ZULLO M.D., F.A.C.C.
425 E 61ST ST, NEW YORK, NY 10065


NAME DATE

**Date of birth** **NYPH#**

**Reason for the visit**

**List all major illnesses**:

**Please tell us about your past medical history**:

1) **List all surgeries, indicate**
**type,** **date** **where they were performed**

2) **List all other hospital admissions** ( for non surgical problems).

3) **List all your medications.**
Name Pill strength # of times taken during the day

**SBE precautions?** ( do you take antibiotics before dental procedures _ **Yes** _ **No**

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425 E 61ST ST, NEW YORK, NY 10065


NAME DATE

**4) List all non-prescription medications** (including, vitamins, calcium and other supplements, pain medication, allergy, cold medication, herbal medicines)

**List all allergies to**

1. Medication
2. Food
3. Are you allergic to Iodine? __ yes _ No
4. Are you allergic to shellfish?. __ yes _ No

**Family history:**

| | | | |
|---|---|---|---|
| 1) father | alive<br>Deceased | age<br>age | Medical condition: |
| 2) mother | alive<br>Deceased | age<br>age | Medical condition: |
| 3) Brothers | alive<br>Deceased | age (s)<br>age | Medical condition |
| 3) Sisters | alive<br>Deceased | age (s)<br>age | Medical condition |

| | | | | | |
|---|---|---|---|---|---|
| 4) Sons | alive<br>Deceased<br>Medical condition: | age(s)<br>age | Daughters | alive<br>Deceased<br>Medical condition: | age (s)<br>age |

**Social History**

Tobacco Did you ever smoke cigarettes, cigars, pipe?
How many per day?
For how many years?
Do you smoke now?
When did you quit?

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425 E 61ST ST, NEW YORK, NY 10065


NAME DATE

**Social History:**
Alcohol ( wine, Beer, Liquor)
How many drinks per day
How many days per week

**Social History**
Diet Low fat
Low salt
Vegetarian ( may include fish)
Regular
Other

**Social History**
Caffeine ( Coffee, tea, colas, chocolate, guarana)
How many total portions per day

**Social History**
Activity No regular exercise:
Regular exercise routine:
Gym sessions per week:
Work related activity:
Leisure time activity:

**Occupation/work**
Currently working as ( type of work)
Retired (type of work)
Disabled (type of work)

Send reports of this consultation to (list referring doctor and his/ her address)