New York Cardiology Associates P.C.

HOLLY S. ANDERSEN, M.D.
FREDERICK J. FEUERBACH, M.D.
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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 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.

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

Medicare

Our physicians have opted out of the Medicare Program. You will be responsible for payment of all charges at the time of visit. Due to government regulations, claims will not be filed to Medicare and you will receive no reimbursement from Medicare for these 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 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, specific pharmacy and/or laboratory designation or pre-certification for procedures.** We will verify referrals, laboratory and/or pharmacy designations 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 upon whether you have out-of-network benefits and the quality of your out-of-network benefits plan.

It is important that you check with your insurance to verify your benefits, as well as the requirements of your insurance for pre-certifications, laboratory and/or pharmacy designations and referrals.

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 you may have. They can be reached at (212) 752-7550.

PAYMENT FOR ALL SERVICES RELATED TO YOUR VISITIS 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**
(Initial) information for treatment, payment, or health care operations.

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

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:** _____

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

Patient's Personal History

New York Cardiology Associates, P.C.
425 East 61st Street – New York, NY 10021
6th Floor Phone: 212-752-2000 Fax: 212-752-5822
4th Floor Phone: 212-752-2700 Fax: 212-752-2949

Patient No. _____

Date _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Birth Place

Address	City	State	Zip	Home Phone	Business Phone

Occupation	Medicare No.	Medicaid No.	Sex	Marital Status	Religion (optional)
			M F		

Insurance Company	Insurance No.

Person to Notify _____ Relationship _____

Address _____ Phone Number _____

Date of Last Physical Examination _____ Doctor _____

Family or Referring Physician _____ Address _____

FAMILY HISTORY		If Living		If Deceased	
	Sex	Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters* *(Circle Sex)*					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters* *(Circle Sex)*					
	M F				
	M F				
	M F				
	M F				
	M F				

**Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.*

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke _____ Epilepsy _____ Heart attack _____ Rheumatic heart _____

Cancer _____ Suicide _____ Colitis _____ Congenital heart _____

Leukemia _____ Migraine _____ Kidney disease _____ Insanity _____

Tuberculosis _____ Asthma _____ Goiter _____ Colon cancer _____

Diabetes _____ Hay fever _____ Arthritis _____ Nervous breakdown _____

High blood pressure _____ Bleeding tendency _____ Stomach ulcers _____ _____

PERSONAL HABITS: (Circle)

Yes No Did you ever smoke? Cigarettes__ Pipe__ Cigars__# years?__ How many daily?___ Date stopped?_____

Yes No **Do you usually drink over 6 cups of coffee per day?**

Yes No **Do you regularly drink alcohol? 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ over 6 oz. ☐**
BEER: 1 bottle per day ☐ 2 bottles per day ☐ over 4 bottles per day ☐.

Yes No **Do you have difficulty in falling asleep?**

Yes No **Do you awaken early in the morning without apparent cause?**

MEDICATIONS:

Are you presently taking any of the following medications? (Circle)

Yes	No	Aspirin, bufferin, anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or poor blood medications	Yes	No	Barbiturates
Yes	No	Laxatives	Yes	No	Birth control pills
Yes	No	Sleeping pills	Yes	No	Phenobarbital
Yes	No	Thyroid medicine	Yes	No	Other drugs not listed

List medication taken and dosage:

Medication	No. of times per day	Dosage
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

List medication taken and dosage:

Medication	No. of times per day	Dosage
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

Check immunizations and date:

___Tuberculin_____ ___Polio (oral)_____ ___Varivax (Chicken Pox)_____

___Pneumococcal (vaccine)_____ ___Polio (injection)_____ ___MMR_____
(Measles, Mumps and Rubella)

___Hepatitis A_____ ___Tetanus and Diphtheria_____

___Hepatitis B_____ ___Other_____

Write in names and year of any operations that you have had:

_____

_____

Name any drugs to which you are allergic:

_____

Write in the names of any diseases that you have had which required hospitalization:

_____

_____

Serious illnesses that you have had: (not requiring hospitalization)

_____

_____

Serious injuries or accidents:

_____

_____

_____

To be answered by WOMEN only: (Circle)

Yes	No	Are you still having regular monthly menstrual periods?	
Yes	No	Have you ever had bleeding between your periods?	When? _____
Yes	No	Do you have very heavy bleeding with your periods?	When? _____
Yes	No	Do you feel bloated and irritable before your period?	
Yes	No	Are you now on or have you ever taken the birth control pill?	When? _____
Yes	No	Have you ever had a miscarriage?	When? _____
Yes	No	Have you ever had a discharge from the nipple of your breast?	When? _____
Yes	No	Do you regularly have the cancer test of the cervix?	Date of last test _____

How many children born alive _____
How many stillbirths _____
How many premature births _____
Date of last menstrual period _____

How many miscarriages _____
How many cesarean operations _____
Any complication of pregnancy _____

To be answered by men and women: (Circle)

Yes	No	Do you frequently have severe headaches? (If yes, answer the following):
Yes	No	Do they cause visual trouble?
Yes	No	Do they occur on one side of the head?
Yes	No	Do they awaken you at night from sleep?
Yes	No	Do they feel like a tight hat band?
Yes	No	Do they hurt most in the back of the head and neck?
Yes	No	Does aspirin relieve them?

Yes	No	Have you ever fainted?	Yes	No	Have you ever had a convulsion?
Yes	No	Spells of dizziness?	Yes	No	Double vision?
Yes	No	Spells of weakness of an arm or leg?	Yes	No	Pains in ear?
Yes	No	Ringing in ears?	Yes	No	Nosebleeds?

Yes	No	Do you frequently have bleeding gums?	Yes	No	Do you frequently have a sore tongue?
Yes	No	Do you frequently have trouble swallowing?	Yes	No	Do you frequently have nausea and vomiting?
Yes	No	Do you frequently have hoarseness?			

Have you ever had shortness of breath?: (Circle)

Yes	No	Doing your usual work?	Yes	No	Which causes you to cough?
Yes	No	Climbing a flight of stairs?	Yes	No	Accompanied by wheezing?
Yes	No	Which awakens you at night?	Yes	No	Have you ever coughed blood?
Yes	No	Do you have a chronic cough?	Yes	No	Do you cough up much sputum?

Have you ever had chest pain or tightness in the chest which begins when: (Circle)

Yes	No	When exerting yourself?	Yes	No	Radiates down the arm?
Yes	No	When walking against a wind?	Yes	No	Disappears if you rest?
Yes	No	When walking up a hill?	Yes	No	Occurs only at rest?
Yes	No	After a heavy meal?	Yes	No	When walking fast?
Yes	No	When upset or excited?	Yes	No	When walking in cold weather?
Yes	No	Palpitations			
Yes	No	Do you sleep on more than one pillow?			

If you have chest pain or tightness please explain _____

Have you recently had pain in the stomach which: (Circle)

Yes	No	Occurs 1 – 2 hours after a meal?
Yes	No	Is brought on by eating fried foods, gassy foods?
Yes	No	Awakens you at night?
Yes	No	Is relieved by antacid medications?
Yes	No	Is relieved with milk or eating?
Yes	No	Occurs while eating or immediately after?
Yes	No	Is relieved by a bowel movement?
Yes	No	Loss of appetite?

If you have had a change in bowel habit recently answer the following: (Circle)			When or since when?
Yes	No	Crampy pain in the abdomen?	
Yes	No	Alternating diarrhea and constipation?	
Yes	No	Pain during or after bowel movement?	
Yes	No	Mucous in the stool?	
Yes	No	Blood in the stool?	
Yes	No	Ribbon-like stools?	
Yes	No	Black stools?	
Yes	No	Require use of strong laxatives or enemas?	
Have you had: (Circle)			
Yes	No	Burning when urinating?	
Yes	No	Loss of control of bladder?	
Yes	No	Blood in the urine?	
Yes	No	Dark colored urine?	
Yes	No	Trouble starting to urinate?	
Yes	No	Trouble holding the urine?	
Yes	No	Getting up frequently at night?	
Yes	No	Passed a kidney stone?	
Have you recently had: (Circle)			
Yes	No	Pains in calves of legs when walking?	
Yes	No	Cramps in legs at night?	
Yes	No	Pain in the big toe?	
Yes	No	Varicose veins?	
Yes	No	Phlebitis or inflamed leg veins?	
Yes	No	Swelling in the ankles?	

To be answered by MEN only: Have you ever had: (Circle)

Yes	No	Loss of sexual activity? For how long? _____
Yes	No	Treatment for genitals (private parts)?
Yes	No	Discharge from penis?
Yes	No	Hernia (rupture)?
Yes	No	Prostate trouble?

Describe briefly your present medical symptoms: