Tamburrino Cardiology & Medical Associates

Patient Information

Last Name: _____ **First Name:** _____ **M.I.:** _____

Date of Birth: ___/___/_____ **Age:** ____ **SSN**: ____-____-_____ **Sex:** M/F **Marital Status**: S M D W

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____**Cell Phone:** _____ **Email:** _____

Occupation: _____ **Employer:** _____

Employer Address: _____ **Employer Phone:** _____

Referring Physician: _____ **Referring Physician Phone:**_____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ **City:** _____ **Zip Code:** _____

Emergency Contact

Name: _____ **Relationship:** _____

Primary Phone: _____ **Secondary Phone:** _____

Primary Insurance please provide a copy of insurance card

Insurance Carrier: _____ **Policy ID:** _____**Group #**_____

Subscribers Name: _____ **Relationship to Patient:** _____

Secondary Insurance please provide a copy of insurance card

Insurance Carrier: _____ **Policy ID:** _____**Group #**_____

Subscribers Name: _____ **Relationship to Patient:** _____

Insurance Authorization Assignment

I certify that have insurance coverage with the above named insurance company(ies). I authorize Tamburrino Cardiology & Medical Associates to furnish information to insurance carrier concerning my illness and I assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance.

Patient/ Guardian Signature: _____ **Date:** _____

Tamburrino Cardiology & Medical Associates

Medication Information

Please indicate conditions you are experiencing or have experienced:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Stroke / CVA
- ☐ Pacemaker Placement
- ☐ Defibrillator Placement
- ☐ High Cholesterol
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes
- ☐ Arthritis

Please list any other conditions you may have that were not listed:

_____

_____

_____

_____

_____

Please list any past surgeries you have had:

_____

_____

_____

_____

_____

Please list any allergies:

- ☐ No known drug allergies
- ☐ No known food allergies
- ☐ Aspirin
- ☐ Penicillin's
- ☐ Codeine Sulfate
- ☐ Bactrim
- ☐ Sulfa (Sulfonamide Antibiotics)
- ☐ Milk
- ☐ NSAIDs (Non-Steroidal Anti-Inflammatory Drug)
- ☐ Eggs
- ☐ Peanuts
- ☐ Latex
- ☐ Iodine and Iodine Products

Other:_____

List all current medications:

Name Dosage/Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Tamburrino Cardiology & Medical Associates

Financial Policy

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care and we want you to completely understand our financial policies. Please read the policy and sign below. A copy will be kept in your chart.

1. **Insurance.** We participate in most major insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected each visit. Keep in mind that your insurance policy is basically contracted between you and your insurance company. Patients without insurance are expected to pay in full at time of service. We accept cash, checks, and most major credit cards.

2. **Co-Insurance.** Your coinsurance, which includes copayments and deductibles, must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles can be considered fraud and will result in our termination of your policy by your carrier. Co-pays that are not paid at time of service will be charged a $10.00 billing fee.

3. **Non-covered services.** Not all insurance plans cover all services. In the event your insurance plan determines a service to be non-covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

4. **Proof of Insurance.** All patients must present a valid insurance card at every visit before seeing the doctor. If you do not provide insurance information at the time of service, you will be held financially responsible for all charges incurred.

5. **Claims Submission.** As a service to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance company does not pay the Practice within a reasonable time period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

6. **Billing and Statements.** Each month you will receive a monthly statement for outstanding balances not covered by your insurance. Payment is due and payable upon receipt. A $10.00 service charge will be assessed monthly on any unpaid balance.

7. **Non-payment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the Practice. If this is to occur, you will be notified that you have 30 days to find alternative care. During that 30 day period, our physician will only be able to treat you on an emergency basis. In addition, you will be responsible for any and all court collection, and/or attorney fees, etc. which will be applied to your unpaid balance.

I have read and understand the Practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the Practice from time to time.

Patient/ Guardian Signature: _____ **Date:** _____

Tamburrino Cardiology & Medical Associates

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

With my consent, Tamburrino Cardiology and Medical Associates may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO)

With my consent, Tamburrino Cardiology and Medical Associates may call my home or other designated locations in reference to any items that assist the Practice in carrying out my treatment, payment issues and healthcare operations, such as appointment reminders and insurance items.

Please list the names of people you wish to receive your test results or that we can discuss your Protected Health Information (PHI):

_____

_____

_____

_____

Please initial if we may discuss or release Protected Healthcare Information (PHI) with a member of your household: _____

Please initial if we can leave test results on your answering machine: _____

By signing this form, I acknowledge that I have read the notice of Privacy Practices and I am consenting Tamburrino Cardiology and Medical Associates use of my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO).

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

Patient/ Guardian Signature: _____ Date: _____

Tamburrino Cardiology & Medical Associates

Missed Appointment Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is canceled **LESS THAN** 24-hours before an office visit and 48-hours before a testing appointment. A "no-show" is when a patient misses an appointment without canceling. In either case, we will charge the patient $50 for a missed office visit, $75 for a missed testing appointment, and $275 for a missed nuclear testing appointment.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment. If cancellation is necessary, we require that you call at least 24-hours in advance for an office visit and at least 48-hours for any testing appointment. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call our office to do so. If necessary, you may utilize our voicemail to cancel appointments, within the 24-hour (office visit) and 48-hour (testing appointment) period.

Patient/ Guardian Signature: _____ **Date:** _____

Tamburrino Cardiology & Medical Associates

PATIENT MEDICAL RECORD AUTHORIZATION FORM

Patient Name: _____ Date of Birth: ____/____/_____

Patient Address: _____

Telephone Number: _____ SSN:_____

I hereby authorize _____ (Provider/Practice Name) to release my information to:

Tamburrino Cardiology & Medical Associates of New Jersey
199 Main St. Ste 2B
Keansburg, NJ 07734
(T): 732-787-3456
(F): 732-333-8136

The following information to be disclosed (Please check on box for each item):

____ Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, and insurance records.

____ Medical Record from (insert date) _____ to (insert date) _____

____ Other: _____

I understand that this consent may include disclosure of Alcohol and Drug Abuse, Psychiatric records, and HIV-related information (indicating that I have had an HIV-related test, or have HIV infections, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information that recipient(s) is prohibited from disclosing the information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without my authorization. If you experience discrimination because of the release of disclosure of HIV-related information, you may contact the New Jersey Civil Rights Commission at (973) 648-2700.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be disclosed if the recipient(s), as described on this form, is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

I understand that this authorization may be revoked, by me, at any time.

Patient/ Guardian Signature: _____ Date: _____