LONG ISLAND HEART ASSOCIATES

We put our hearts into healing yours

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name: ______________________________First Name: _______________________________ MI:_____ Gender_______

Social Security: _________________________ Date of Birth: ____________________________

Address: _____________________________________ Apt #_____ City: ____________________State: _____ Zip: _______

Phone #: (H):___________________________ (Mobile):__________________________ (Work):______________________

Email: ____ Marital Status: Married _____ Single_____ Other______

Translator Required: Y/N. If Yes, specify Language:_____________________

Employment: Full Time____ Part Time____ Retired____ Not Employed____ School____

Employer: ____ Phone #:____________________________________

Address: ____ City: _____________________ State: ______ Zip__________

SPOUSE INFORMATION

Last Name: ______________________________First Name: _______________________________ MI:_____ Gender_______

Phone #: (H):___________________________ (Mobile):__________________________ (Work) ______________________

Social Security: _________________________ Date of Birth: ____________________________

Employer: ____

PARENT INFORMATION

(This section is only applicable to full time students or for individuals covered under parents/guardian's insurance policy. Please provide the below information on the parent in which you are covered under)

Parent Last Name:_________________________ First Name:______________________________MI:_____Gender:_______

Social Security: _________________________ Date of Birth: ____________________________

Address: _____________________________________ Apt #_____ City: ____________________State: _____ Zip: _______

Phone #: (H):___________________________ (Mobile):__________________________ (Work): _____________________

Employer: ____

EMERGENCY CONTACT

Last Name: _________________________________First Name: ____________________________________ Gender_______

Relationship to Patient: _______________Primary Number: ___________________ Secondary Number: _______________

Patient Name: ____ DOB:______________________________

PRIMARY CARE PHYSICIAN	**REFERRING PHYSICIAN (If not Primary Care Physician)**
Physician Name:__________________________________	Physician Name:__________________________________
Address:____	Address:____
City:_______________State:________ Zip:___________	City:_______________State:________ Zip:___________
Phone Number:________________________	Phone Number:________________________
Fax:________________	Fax:________________

PHARMACY INFORMATION

Name of Pharmacy:____

Address: ____ City:_____________________ State:______ Zip__________

Phone #:___________________________ (Fax):__________________________

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name:____

Claims Address:_______________________________ City:__________________ State:__________ Zip:____________

Subscriber ID #:_____________________ Group #:_________________________________

Patient's relationship to insured: Self/Spouse/Child/Other

Insured Name (if not self):__________________________ SS#:_____________________ Date of Birth: ___________________

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name:____

Claims Address:_______________________________ City:__________________ State:__________ Zip:____________

Subscriber ID #:_____________________ Group #:_________________________________

Patient's relationship to insured: Self/Spouse/Child/Other

Insured Name (if not self):__________________________ SS#:_____________________ Date of Birth:___________________

HOW DID YOU HEAR ABOUT OUR PRACTICE

Please check One: Referring Physician: ______ Family/Friend: _____ Insurance Company: ____ Newspaper:____

Radio/TV: ____ Internet_______ Other:______________

Billing Policy

Referrals:

It is the patient's responsibility to obtain referrals for initial and follow up visits, which must be presented to the receptionist prior to your visit. If you do not have out of network benefits and you choose to be seen without a referral, you will be responsible for payment of all services. If you choose to use your out of network benefits, arrangements must be discussed with our Billing Coordinator prior to your visit.

Workman's Compensation/No Fault Insurance:

Arrangements with our billing department must be made prior to your visit. Please contact them prior.
Billing Department: (516) 877-0977 Ext: 707

Copayments:

All copayments /co-insurance payments are due at the time of your visit.

Medicare:

We are participating providers of Medicare. Patients are responsible for 20% Medicare co-insurance and/or deductible (if applicable) UNLESS paid by your secondary insurance carrier. If your secondary carrier does not cover your co-insurance in full, you will be billed for the balance.

Medicare HMO:

If you are planning to join or have joined a Medicare HMO plan, you must notify our office/billing department so that we can update your records.

Insurance Policy:

It is the responsibility of the patient/insured to know the terms of their insurance coverage. Deductible/co-insurance withheld from payments is the patient's responsibility. Payments denied due to lapse of coverage/termination, misrepresentation of information **or failure to notify us of changes to your insurance, are the patient's responsibility.**

If you have any further questions or concerns regarding any of the above policies, please feel free to contact our Billing Department/Coordinator with any questions you may have.

I verify the accuracy of the above information. I authorize the disclosure of my medical information and that payment for authorized services is made to the treating physician at Long Island Heart Associates on my behalf.

Signature of Patient: ______________________________ **Today's Date:** ______________________________

Print Name: ____________________________________

Billing Department (516) 877-0977 Ext: 707

PATIENT'S AUTHORIZATION SIGNATURE FORM FOR ASSIGNMENT OF BENEFITS

MEDICARE PART B

"I Request that payment of all authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services."

ALL OTHER INSURANCES

"I hereby authorize any physician, health care practitioner, hospital, clinic or other medical or medically related facility to furnish any and all records, medical history, and services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my insurance company.

I also authorize my insurance company to disclose to a hospital or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of the claim.

If my coverage is under Group Contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurance company including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators."

FINANCIAL RESPONSIBILITY: I do hereby expressly guarantee payment in full of any and all charges in consideration for services rendered by Long Island Heart Associates. This includes but is not limited to, any charges considered by my insurance company or Medicare to be "non-covered services.

Patient (or Authorized) Name: ____

Patient (or Authorized) Signature: ____

Health Insurance Claim Number: ____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from 3rd party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: ____

I allow my records to be released to: ____

Relationship to Patient: ____

Patients Signature: ____

Date: ___________________