PATIENT REGISTRATION

Section 1: Demographics

DEMOGRAPHICS

First Name: ____________ **Last Name:** ____________ **Middle Initial:** ______

Address: ____

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

Date of Birth: ____________ **Social Security Number:** ____________

Email Address: ____________________ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other (please indicate): ____________

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hawaiian ☐ Pacific Islander ☐ Other

ADDITIONAL INFORMATION

Primary Care Physician: ____________ **Referring Physician:** ____________

Pharmacy Name: ____________________ **Pharmacy Type:** ☐ **Retail** ☐ **Mail Order**

Pharmacy Phone Number: ____________

Pharmacy Address: ____

Employment: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed **Student:** ☐ Full-Time ☐ Part-Time

Employer/School Name: ____

Please provide an EMERGENCY CONTACT:

Name: ____________ **Home Phone:** ____________

Cell Phone: ____________ **Relationship to Patient:** ____________

51 Veronica Avenue, Somerset, NJ 08873 | Ph: 732-846-7000 Fax: 732-846-7001
294 Applegarth Road, Suite F, Monroe, NJ 08831 | Ph: 609-642-4747 Fax: 732-846-7001
620 Cranbury Road, Suite 207, East Brunswick, NJ 08816 | Ph: 732-846-7000 Fax: 732-846-7001
Hospital Affiliations: Saint Peter's University Hospital, RWJ University Hospital – New Brunswick, Princeton Medical Center

SECTION 2: INSURANCE INFORMATION

MEDICAL INSURANCE

Primary Insurance Carrier: ______________________ **ID #:** ______________ **Group #:** ________

Secondary Insurance Carrier: ______________________ **ID #:** ______________ **Group #:** ________

Responsible Party: ☐ **Patient** ☐ **Other** *(if other, please complete fields below)*

First Name: ____________________ **Last Name:** ____________________ **Middle Initial:** ________

Address: ____

Home Phone: ______________ **Cell Phone:** ______________ **Relationship to Patient:** ____________

How did you hear about us? Please be as specific as possible:

☐ *Referral (e.g. doctor, family, friend)* ________________________________

☐ *Online Search (e.g. Google, Yahoo, Bing)* ________________________________

☐ *Social Media Page (e.g. Facebook, Yelp, Google)* __________________________

☐ *Health Ratings Site (e.g. HealthGrades, Vitals, RateMDs)* ____________________

☐ *Other (e.g. health insurance portal, newspaper ad, etc.)* ____________________

We hope you had a great experience here with us! We want to ensure that prospective patients can experience the same high quality of care that we were able to provide you.

May we reach out to you to capture your feedback and experience?

☐ *Yes* ☐ *No*

Please provide your best contact details: ________________________________

51 Veronica Avenue, Somerset, NJ 08873 | Ph: 732-846-7000 Fax: 732-846-7001
294 Applegarth Road, Suite F, Monroe, NJ 08831 | Ph: 609-642-4747 Fax: 732-846-7001
620 Cranbury Road, Suite 207, East Brunswick, NJ 08816 | Ph: 732-846-7000 Fax: 732-846-7001
Hospital Affiliations: Saint Peter's University Hospital, RWJ University Hospital – New Brunswick, Princeton Medical Center

SECTION 3: CONSENT FOR COMMUNICATIONS

I request that all communications to me by CMI/CJSS and/or its staff be handled in the following manner:

Address for Written Communication: ☐ *Select if same as address above*

____

For Oral Communication: Please indicate preferred method (*based on phone numbers provided above*)

☐ **Home** ☐ **Cell** ☐ **Work** **Other:** ____________________

I give my permission for Cardio Metabolic Institute to leave a message on my machine.

☐ **Yes** ☐ **No**

Would you like to receive text messages in regard to **non-urgent** updates such as appointment reminders, normal test results or authorizations for procedures?

☐ **Yes** ☐ **No**

If Yes, please review and sign consent below:

I hereby consent to receive text messages from the practice to my cell phone. I understand that this request to receive text messages will apply to all future appointment reminders, test results, and non-urgent communications.

____

The practice does not charge for this service, but standard text messaging and carrier rates may apply. All patients have the right to change their minds and have this service stopped. If you no longer wish to receive text messages please notify reception by phone or in-writing. Please note we cannot accept incoming text messages. If you change your mobile number please inform us, so that we can update our records.

Patient Signature: ____________________ **Patient Name:** ____________________

Date: ____________________

51 Veronica Avenue, Somerset, NJ 08873 | Ph: 732-846-7000 Fax: 732-846-7001
294 Applegarth Road, Suite F, Monroe, NJ 08831 | Ph: 609-642-4747 Fax: 732-846-7001
620 Cranbury Road, Suite 207, East Brunswick, NJ 08816 | Ph: 732-846-7000 Fax: 732-846-7001
Hospital Affiliations: Saint Peter's University Hospital, RWJ University Hospital – New Brunswick, Princeton Medical Center

SECTION 4: FINANCIAL POLICY

Thank you for choosing us as your health care providers. The health care industry is rapidly evolving and with the constant changes in insurance policies and the growing costs of maintaining quality health care services, we have implemented the following financial policy which we ask that you read, accept and acknowledge.

REGARDING COMMERCIAL INSURANCES:

- ***We must have a copy of your current insurance card*.** Therefore it is the responsibility of the patient to make sure you offer your insurance card to the Receptionist for copying if your insurance has changed since your last visit.
- ***If you have an HMO plan with whom we have a contract***, a proper referral from your Primary Care Physician is necessary for you to be seen for both testing and regular office visits. This referral must contain the diagnosis, number of visits allowed and have an expiration date. It is the patient's responsibility to keep track of the number of remaining referrals. You may call our office at any time to verify this information prior to your visit. **If you are seen without a valid referral, you will be responsible for the bill.**
- ***If you have a co-pay on your card***, you will be responsible for the payment of that co-pay on the day of your appointment. All co-pays are collected upon arrival.
- ***If you have a PPO plan with which we have a contract*,** you will be responsible for the co-pay if listed on your card. If you have not met your deductible, or if you have a co-insurance that remains after the insurance company has paid their portion, you will be responsible for this balance and payment will be expected.
- ***If your insurance requires a co-pay for testing,*** you are responsible for payment of both the co-pays.
- ***If your insurance has lapsed in coverage***, or is not in effect at the time of service, You will be responsible for payment of services

REGARDING MEDICARE PATIENTS:

- ***Patients are responsible for meeting their annual deductible each year***.
- ***Once the deductible has been met*,** patients without secondary insurance will be required to pay their 20% portion at the time of their visit.
- ***If you have secondary/supplementary insurance*** it is the responsibility of the patient to provide our staff with a copy of that card.
- ***We will file with secondary/supplementary carriers***; however, in the event that the secondary insurance does not pay, patients will be billed for the balance.

REGARDING MOTOR VEHICLE ACCIDENT (MVA) PATIENTS:

- ***Patients are responsible for meeting the deductible on their motor vehicle insurance policy***
- ***If you have supplementary insurance*** it is your responsibility to provide our office with that information. If necessary, we will bill your supplementary insurance for costs that your MVA insurance does not pay for.
- ***In the event that the supplementary insurance does not pay***, patients may be billed for the balance unless alternate payment method has been agreed upon between our office and the patient or the attorney involved.

Patient Initials: _______________

NON-PARTICIPATING INSURANCES AND SELF-PAY PATIENTS:

- ***If you have presented us with a health insurance card with which we do not participate***, you will be expected to pay 100% of our billed amount at the time the services are rendered.
- ***Once payment is made by you***, the claim will be submitted to your health insurance carrier on your behalf. Any reimbursement due you for out of network benefits should be sent directly to you. If your insurance company mails the payment to our office, a refund check will be sent to you in the amount paid by the insurance company.

PARTIAL PAYMENTS/PAYMENT PLANS:

- ***Partial payments will only be accepted if prior arrangements have been made***.
- ***If you wish to proceed with any necessary testing*** and would like to set up a payment plan, this can be arranged with our staff. Payment plans can only be set up with credit or debit card information.
- ***Once a payment plan is arranged***, payments must be made consistently or the balance will be considered delinquent. You may be subject to finance charges or eventually turned over to our collection agency.

DELINQUENT ACCOUNTS:

- ***Delinquent accounts will be subject to monthly billing charges until the account is settled in full***.

OUR CANCELLATION POLICY:

- ***We require 24 hour notice for all cancelled appointments*** or your account will be charged $25.00. Please be aware that this charge is your responsibility and is not covered by your insurance.
- ***In addition there will be a $25.00 charge for all no-shows***.

DIAGNOSTIC TESTING: (FOR ALL PATIENTS)

Please be aware that following your office visit the doctor may order diagnostic testing that may not be deemed "medically necessary" by either Medicare or your insurance carrier. It is possible that your insurance carrier has made its own determination as to what tests they deem to be "medically necessary". Therefore, there may be charges not covered by your carrier. In such an event, these charges will become the responsibility of the patient

INSURANCE AUTHORIZATION AND ASSIGNMENT: (FOR ALL PATIENTS)

I request payment of Medicare and / or participating managed care products be made payable to Cardio Metabolic Institute / Central Jersey Sports & Spine on my behalf for any services provided to me by this Practice. I authorize the release of any information about me to Medicare and / or other participating managed care products and its agents that may be needed to determine these benefits.

Patient Initials: ________________

51 Veronica Avenue, Somerset, NJ 08873 | Ph: 732-846-7000 Fax: 732-846-7001
294 Applegarth Road, Suite F, Monroe, NJ 08831 | Ph: 609-642-4747 Fax: 732-846-7001
620 Cranbury Road, Suite 207, East Brunswick, NJ 08816 | Ph: 732-846-7000 Fax: 732-846-7001
Hospital Affiliations: Saint Peter's University Hospital, RWJ University Hospital – New Brunswick, Princeton Medical Center

FINANCIAL RESPONSIBILITY FOR PAYMENT

I am aware that due to any of the reasons listed below, it may be possible that my insurance carrier will deny payment for services rendered to me today. In that event, I understand that I will be financially responsible for those charges.

- I do not have my insurance card with me
- I do not have a valid referral for this visit
- This office does not participate with my insurance carrier
- I do not have health insurance and will pay for my visit today

I have read the above Financial Policy and understand and agree with its terms.

______________________________ ______________________________ ____________________
Signature Print Name Date

SECTION 5: HIPAA COMPLIANCE AND PRIVACY POLICIES

Our office is fully committed to compliance with HIPPA guidelines by:

1. Providing appropriate security for our patient records
2. Protecting the privacy of our patient's medical information
3. Providing our patient with proper access to their medical records
4. Appropriately maintaining our patient information and billing processes in compliance with national standards

I have read and understood the terms of the HIPAA. I have been advised of the details of the HIPAA Omnibus Notice of Privacy Practices and am acknowledging my right to obtain a copy of this document at any time that I choose.

______________________________ ______________________________ ____________________
Signature Print Name Date

Patient Protected Health Information Disclosure Authorization

Listed below are the names of the individuals with whom the physicians and staff at the Heart & Vascular Center of New Brunswick, LLC DBA Cardio Metabolic Institute DBA Central Jersey Sports & Spine have my permission to disclose and discuss my protected health information with. Any information that relates to my past, present or future physical/mental health or condition and other related healthcare services may be discussed. I understand that his authorization will remain in effect until I make a written request to change it.

1) Name: ______________________________ Relationship: ______________________________

2) Name: ______________________________ Relationship: ______________________________

3) Name: ______________________________ Relationship: ______________________________

4) Name: ______________________________ Relationship: ______________________________

Patient Name: ____________________________ Patient Signature: ____________________________

Patient Date of Birth: ______________________ Date: ____________________________

Patient Consent for Use and Disclosure Of Protected Health Information: Medication History

I hereby give my consent for Heart & Vascular Center of New Brunswick, LLC DBA Cardio Metabolic Institute DBA Central Jersey Sports & Spine to obtain my medication history to carry out treatment and provide me with healthcare services.

With this consent, Heart & Vascular Center of New Brunswick, LLC DBA Cardio Metabolic Institute DBA Central Jersey Sports & Spine may call my home or other alternative locations like the pharmacy or other physician's office or electronically from my health plan information regarding my medication history.

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 / Legal Guardian Name: ______________________________ **Date:** ____________________

Patient / Legal Guardian Signature: ____________________________ **Date:** ____________________