GARDEN STATE HEART CARE

831 TENNENT ROAD
MANALAPAN NJ 07726

201 NORTH COUNTY LINE ROAD
JACKSON NJ 08627

Jatinchandra Patel, DO John Covalesky, DO Aaron VanHise,DO

2 HOSPITAL PLAZA, SUITE 450
OLD BRIDGE NJ 08857

REGISTRATION FORM

Primary Care Doctor:_____ Referring Doctor [if different]:_____

PATIENT INFORMATION

Name:[Last]_____ [First]_____ [MI]_____

Date of Birth:_____ Age:_____ Sex: _____Male ____Female

Social Security #:_____ Marital Status:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Email Address:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Employer:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Garden State Heart Care, PC or my insurance company to release any information required to process my claims.

X_____ _____

Patient/Legal Guardian Signature Date

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MEDICAL HISTORY

Name:_____ DOB:_____

Height:_____ Weight:_____

Reason for Today's Visit?_____

Pharmacy:_____

Pharmacy Address:_____City:_____

ALLERGIES:_____

MEDICATIONS [include Aspirin] – Name, Dose [mg], Frequency

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

MEDICAL HISTORY

☐ Heart Attack/Heart Stents	☐ Atrial Fibrillation	☐ Sleep Apnea
☐ Congestive Heart Failure	☐ Pacemaker	☐ Kidney Disease
☐ Bypass Surgery [CABG]	☐ Blood Clots – DVT/PE	☐ Liver Disease – Hepatitis / Cirrhosis
☐ High Blood Pressure	☐ PAD – Leg Blockages	☐ Seizures
☐ High Cholesterol	☐ Lymphedema	☐ Thyroid Disorder
☐ Stroke/TIA	☐ Diabetes Mellitus	☐ Cancer

ADDITIONAL MEDICAL HISTORY

SURGERIES

PRIOR HOSPITALIZATIONS

_____ _____ _____

FAMILY HISTORY – IE BLOOD CLOTS, STROKE, HEART ATTACK

Father: _____Alive _____ Deceased Medical problems:_____

Mother: _____Alive _____ Deceased Medical problems:_____

SOCIAL HISTORY

Tobacco: _____Never ____Current Smoker _____Former Smoker – When did you quit? _____

Alcohol: _____No ____Yes – How often_____

Exercise: _____No _____Yes - How Often: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have had the opportunity to review the *Notice of Privacy Practices*, and provided a copy [if requested].

Patient Signature _____ Date _____

Patient Name _____ Date of Birth _____

Please provide the name[s] of individuals who Garden State Heart Care, PC may provide information regarding your care/condition:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

By signing below, you authorize Garden State Heart Care to obtain medical records from your doctors or hospitals.

Patient Name:_____ Date of Birth:_____

Patient Address:_____

City:_____ State:_____ Zip:_____

I hereby authorize _____
Name of physician's office/facility disclosing information

to disclose the following protected health information to:

Garden State Heart Care, PC
831 Tennent Road
Manalapan NJ 07726
Fax 732-851-4703

Information to be Disclosed:_____

Date Range of information requested: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to Garden State Heart Care. I understand that the revocation does not apply to the information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome [AIDS], or human immunodeficiency virus [HIV], sexually transmitted diseases, tuberculosis, or genetics. Please initial here if you do NOT want this information to be released:_____

Unless otherwise revoked, this authorization will expire in 6 months or on the following date:_____

_____ _____
Patient Signature Date

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OFFICE POLICIES & PROCEDURES

Thank you for choosing Garden State Heart Care. We strive to provide you with the best cardiovascular care and request your cooperation as outlined below.

OFFICE HOURS

Our office is available Monday-Friday 8:30am to 5:30pm.
For after-hour emergencies, one of our physicians is available 24hrs/7 days a week via calling our office.
For prescription refills or test results, please call during normal business hours.
We may request that an appointment be made to review testing after completed.

APPOINTMENTS

While we strive to schedule appointments appropriately, emergencies do occur.
Please be understanding should a delay or rescheduling become necessary.
Garden State Heart Care does not render care for patients we have not yet seen (i.e. we will not call in prescriptions or offer medical advice for patients prior to their initial visit).

APPOINTMENT CANCELLATIONS

Please cancel with 24 hours advanced notice, so other patients can be scheduled.

NO-SHOW POLICY

Failure to cancel with 24 hours advanced notice will be labelled a “no-show” in your chart.
An administrative fee of $35.00 MAY be billed to your account for this missed appointment.
Three (3) “no-shows” within one (1) calendar year MAY result in a temporary suspension of services or dismissal from the practice. Certainly we understand that last minute emergencies may arise in your schedule and simply request you notify us as soon as you are aware there is a conflict.
A no-show for a Nuclear Stress Test may result in charges for the current cost of the radio-isotope [chemical that is injected for the test] with approximate cost of $200 [variable].
No-Show charges are the patient’s responsibility and cannot be billed to your insurance company.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

Refills can be made at the time of your office appointment, so please review your medications prior to your appointment. Please allow two business days for refill requests not made during your office appointment.
We do not routinely refill medications during the weekend.
Please note that we do <u>not</u> routinely fill narcotic medications or controlled substances.

FORMS/LETTERS

Please allow 7 business days for completion of requested forms/letters [ie medical clearance, disability].

MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical record one time at no charge. Additional copies may be requested at a cost of $0.75 per page. HIPAA guidelines allow medical offices 30 days to complete requests for records. However, records are often available sooner.

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INSURANCE/Co-PAY POLICY

It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment.

Patients are responsible for co-pays at the time of service. If you cannot pay your co-pay at the time of the visit, you may be asked to re-schedule; we do not send bills for co-pays.
The patient is also responsible for any residual balance for services rendered that are not covered by insurance [if applicable/allowed in your insurance contract].

PAYMENTS

Garden State Heart Care accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to *Garden State Heart Care*. [Checks returned with non-sufficient funds will result in a $50 administrative charge].

We will attempt to collect all outstanding balances including with convenient payment arrangements. Failure of these attempts will result in third party collection for the balance and any associated administrative costs to collect the balance.

GUIDELINES FOR PROFESSIONAL BEHAVIOR

Just as our patients expect professional behavior from our physicians and our staff, that same level of respect is expected of our patients. Although rare, there are instances in which the physician-patient relationship may be terminated by Garden State Heart Care, as listed below:

- Treatment nonadherence—The patient does not or will not follow the treatment plan after understanding the outlined plan of care.
- Follow-up nonadherence—The patient repeatedly cancels follow-up visits or is a no-show.
- Verbal abuse—The patient or a family member is rude/disrespectful and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.
- Nonpayment—The patient owes a backlog of bills and has declined to work with the office to establish a payment plan.
- False Information – The patient knowingly provides false information regarding insurance, past history, medications or other details regarding your medical history.
- Impairment – The patient presents in the office under the influence of alcohol or illicit drugs.

We will make attempts to resolve any issues via face-to-face office encounters to the satisfaction of both parties. However, in the rare instance that the physician-patient relationship is terminated, we will provide you with 30 days written notice with the reason for termination; a copy of your medical record will be provided free; any prescriptions will be renewed during this 30 day period; emergency medical care will be provided during this 30-day period or beyond until stable.

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OFFICE POLICIES & PROCEDURES

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Garden State Heart Care OFFICE POLICIES & PROCEDURES Form.

_____ _____/_____/_____
Signed Name Date of Birth

_____ _____/_____/_____
Printed Name Today's Date