Annapolis Cardiology Consultants, LLC

Patient Information:

Patients full name: ____ Sex: ( ) Male ( ) Female

Address: ____

City: ____________________________ State: _____________ Zip: ______________

Race: _________________ Ethnicity: _________________ Primary Language: __________________

(PLEASE CIRCLE)

YES/NO: I reside in a skilled nursing facility. If so, name of skilled nursing facility is:

____

Home # ___________________________ Work # _________________________ Ext.___________

Cell # _____________________________ E-mail address: _____________________________________

Date of birth: ________________________ Social Security # ____________-___________-___________

Marital Status: ( ) Single ( ) Married ( ) Other ____

Patient's employer: ____

Referring Doctors Name: _________________________ Primary Care Doctors Name: ______________________

Emergency Information:

Person to contact in case of an emergency: ____

Phone # ________________________________ Relationship to patient: ______________________________

Insurance Information:

-Primary Insurance: ______________________________ Policy Holders Name: ___________________________

Policy# ____ Group # ____________________________________

Policy Holders Social Security # __________-_________-__________ Date of Birth: _______________________

Relationship to patient: _____________________________ Employers Name: ____________________________

-Secondary Insurance: ____________________________ Policy Holders Name: ___________________________

Policy # ____ Group # ____________________________________

Policy Holders Social Security # __________-_________-__________ Date of Birth: _______________________

Relationship to patient:_____________________________ Employers Name: ____________________________

Patient Assignment of Benefits: I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company(s), I will be held directly responsible for all the fees incurred with Annapolis Cardiology Consultants, L.L.C. I authorize payment of medical benefits to the physician or supplier for all services rendered. I also authorize release of any medical or other information necessary for processing of my claims.

____

Patient Signature Date

Annapolis Cardiology Consultants, LLC

Patient Name:	
Date of Birth:	Social Security:
MEDICATION ALLERGIES/DESCRIBE REACTION	

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescription and over-the counter- medications (example: aspirin, antacids) and herbals (example: ginseng, ginko). Include medications taken as needed (example: nitroglycerin).

NAME OF MEDICATION	DOSAGE (example: mg, ml, grams, etc.)	DIRECTIONS (example: once a day, twice a day, etc.)	PRESCRIBING DOCTORS NAME

Acknowledgement of Receipt

Annapolis Cardiology Consultants, LLC

NOTICE OF PRIVACY PRACTICES

By signing this page you acknowledge that you have received a copy of our Notice of Privacy Practices.

Name of Patient: ____

Signature of Patient: ____
(or Personal Representative)

Name of Personal Representative: _____________________________________
(if not patient)

Date Signed: ____

Witnessed by: ____

Effective Date: 5/1/03

Annapolis Cardiology Consultants, LLC
2002 Medical Parkway, Suite 310
Annapolis, MD 21401
Tel: 410-224-0040 Fax: 410-224-4232

Marco A. Mejia, M.D., F.A.C.C. S. Ingo Ender, M.D., F.A.C.C.
Boaz Rosen, M.D., F.A.C.C. Sadia J. Shafi, M.D.

___I hereby authorize Annapolis Cardiology Consultants, LLC to release information concerning my medical care to the following individual(s).

NAME OF INDIVIDUAL	***RELATIONSHIP TO PATIENT***

___I hereby authorize Annapolis Cardiology Consultants, LLC to release information related to my bill with the following individual(s).

NAME OF INDIVIDUAL	***RELATIONSHIP TO PATIENT***

These authorizations are subject to the following limitations and/or restrictions:
____
____
____
____.

___I DO NOT want Annapolis Cardiology Consultants, LLC to disclose any information concerning my medical care, treatment or billing to individuals without my written consent or legal authorization.

____
Patient name (printed)

____ _____________
Patient signature ***Date***

_________________________ _____________
Witness ***Date***

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Payment Policy

Thank you for choosing us as your cardiology provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate with most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments **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 co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. 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. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 60 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 this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Please help us to serve you better by keeping your regularly scheduled appointment. Any diagnostic appointment (echocardiograms, stress test, stress echocardiograms and all doppler/ultrasound studies) that are not cancelled at least 48 hours prior to the appointment time, will be charged a $25.00 missed appointment fee. Also, more than 3 missed physician appointments not cancelled at least 48 hours prior will be charged a $25.00 missed appointment fee. These charges will be your responsibility and billed directly to you.

9. Referrals. If your insurance requires a referral and you fail to provide a valid referral to our office, you agree that you will be financially responsible for all services provided.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines:

______________________________________ ______________________

Signature of patient or responsible party **Date**

____

Printed name