

GARDEN STATE CARDIOLOGY



Dear New Patient,

Welcome to our office! This letter is to introduce you to our office and our policies. We will ask you to sign an acknowledgment that you received this letter and understand it at the time of check-in for your visit.

We are located at 1124 East Ridgewood Avenue, Suite 202, on the second floor of the Pondview Medical Center. The building is located on Ridgewood Avenue across from the Duck Pond. There is a Boiling Springs Bank on the first floor. If you know the area, the building used to be the McHugh clothing store.

We are enclosing some patient information for you with this letter. Please complete the forms and bring them with you to your appointment to help speed up the check-in process. We will need you to arrive for your appointment 20 minutes prior to the appointment time so that we can get all the paperwork together and set up your chart to be ready for your appointment time.

HOURS: Our office hours for phone calls are Monday through Friday 9:00AM - 5:00 PM. If you are unable to keep your upcoming or future appointments, we ask that you give us at least 24 hours notice so that we can use that time for someone else who may have an urgent need. It is possible that your appointment could be delayed or rescheduled if the doctor has to leave the office for an emergency. We will do everything possible to still see you that day or fit you into the schedule at another time.

EMERGENCIES: Our doctors rotate being on-call for each other after hours throughout the week, weekends, holidays, vacations and days off. If you have a medical emergency, call our main phone number (201) 689-9400 and the on-call physician will be paged. Do not call any other phone number besides the main number, otherwise you may not reach the on-call doctor.

FINANCIAL: If you have insurance, please bring your most current insurance identification cards to your appointment. Please check your card(s) to see if they have expiration dates on them. We must copy both sides of the card(s) and your driver's license for your record. If you do not have your insurance card(s), you must call your insurance company or human resources director at the place of employment where you are receiving insurance benefits. This needs to be done prior to your appointment not after you arrive at the office. If you do not have all of this information you will either need to pay cash for your visit or reschedule your appointment to the next available time slot when you do have the information. Obtaining the proper referrals as required by your insurance is your responsibility, and must be done before arriving before your appointment.

The hospitals we use are Valley Hospital and St. Joseph's Regional Medical Center. It is important that you know what insurance benefits you have and what hospital you are allowed to go to. We are unable to know all the benefits for the dozens of insurance plans we work with because there are too many and the benefits are so varied between plans and carriers.

Thank you and we look forward to meeting you soon!

The Doctors and Staff of Garden State Cardiology

GARDEN STATE CARDIOLOGY

NEW PATIENT INFORMATION



Date _____

Patient's Last Name _____ First Name _____

Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex: M F Phone: _____ Marital Status _____

Referring Physician _____ Family Physician _____

INSURANCE INFORMATION

Policy Holder's Last Name _____ First Name _____ Sex M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Date of Birth _____ SS# _____

Policy Holder's Employer _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

PRIMARY INSURANCE _____ Policy Holder's Group # _____

Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE _____ Policy Holder's Group # _____

Address _____ City _____ State _____ Zip _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process this claim.

_____ Date _____

I authorize payment of medical benefits to the physician or supplier for medical services provided.

_____ Date _____

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers or to the billing agent of this physician, any information needed for any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of these benefits either to myself or to the party who accepts assignment.

_____ Date _____

GARDEN STATE CARDIOLOGY

FINANCIAL POLICY



It is the policy of Garden State Cardiology to have a Financial Policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid misunderstanding or disagreement concerning payment for professional services.

Garden State Cardiology participates with numerous insurance companies. For patients that are members of these plans, our business office will submit a claim for services rendered. The patient must complete all necessary insurance information, including special forms, before leaving the office.

It is the patient's responsibility to pay any deductible, co-insurance, or any portion of the charges as specified by the plan at the time of visit. Co-payment is expected to be paid prior to the patient seeing the physician or practitioner. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.

If the patient is unable to determine amount of deductibles, co-insurance or co-payment, the receptionist is authorized to use an estimated amount of 20% coinsurance, \$250.00 deductible or \$25.00 copayment as needed for that office visit or procedure. If the patient has a deductible greater than \$300 that they claim has already been met, the receptionist may require proof that it has been met. Proof usually will be a recent EOB from patient showing deductible met or deductible remaining.

Payment for professional services can be made with cash, check, MasterCard, Visa, or American Express.

If a patient feels that he or she may require financial assistance, notify the practice receptionist before you see the physician, for referral to the appropriate individual. Patients that do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.

It is the patient's responsibility to ensure that any required pre-certifications or referrals for treatment are provided to the practice before the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of referral or pre-certification.

It is the patient's responsibility to provide us with current demographic and insurance information and to bring their insurance card to each visit.

Garden State Cardiology business office representatives will assist with insurance questions relating how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company's member services department (telephone number on your member id card)

In the event a patient is unable to pay the full amount due today, the receptionist will have the patient/guarantor fill out the promissory note. This note is a legal agreement and breach of the agreement will lead to the account being turned over to collection agency by business office representatives. All accounts are to be paid off in 12 months with a minimum payment of \$30.00 per month.

Garden State Cardiology firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the business office. We are here to help you. **Please sign that you have read and agree to this Financial Policy.**

Signature of Patient/Responsible Party

Date

GARDEN STATE CARDIOLOGY
PATIENT COMMUNICATION AUTHORIZATION



Patient Name: _____

I authorize physicians and staff of GARDEN STATE CARDIOLOGY to communicate and/or leave messages for me at the following locations:

	<u>Calling OK?</u>	<u>Messages OK?</u>	<u>Phone number and extension</u>
HOME	yes / no	yes / no	_(_____)_____
WORK	yes / no	yes / no	_(_____)_____
CELL	yes / no	yes / no	_(_____)_____
PAGER	yes / no	yes / no	_(_____)_____

Persons authorized to receive information about my healthcare:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Emergency contacts:

CONTACT #1

CONTACT #2

Name:	_____	_____
Relationship:	_____	_____
Home Phone:	_(_____)_____	_(_____)_____
Work Phone:	_(_____)_____	_(_____)_____
Cell Phone:	_(_____)_____	_(_____)_____
Page:	_(_____)_____	_(_____)_____

I acknowledge that this authorization can only be amended or rescinded by my written authorization:

Patient: _____

Signature: _____

Date: _____

Garden State Cardiology

New Patient Information Form

NAME: _____ DATE OF BIRTH: _____

TODAY'S DATE: _____

Who referred you to our office, and why? _____

Current medications: _____

Do you have these conditions? (Circle your answer):

High blood pressure:	Yes - No	Heart attack:	Yes - No
Diabetes:	Yes - No	Heart failure:	Yes - No
High cholesterol:	Yes - No	Stroke or mini-stroke:	Yes - No
Current smoker:	Yes - No	Coronary artery disease:	Yes - No
Former smoker:	Yes - No	Vascular disease:	Yes - No
		Family history of heart disease:	Yes - No

Explain any "Yes" responses here: _____

Allergies: _____

Other physicians you see: _____

Have you noticed any of these symptoms?

Chest pain:	Yes - No	Blood in stool:	Yes - No
Shortness of breath:	Yes - No	Fever:	Yes - No
Fainting:	Yes - No	Blood in urine:	Yes - No
Calf pain with walking:	Yes - No	Cough:	Yes - No
Leg swelling:	Yes - No	Muscle pain:	Yes - No
Palpitations:	Yes - No	Dizziness:	Yes - No
Need to sleep upright:	Yes - No	Rashes:	Yes - No
		Vision loss:	Yes - No
		Memory loss:	Yes - No
		Depression:	Yes - No

Explain any "Yes" responses here: _____

Other family medical history: _____

Alcohol consumption: _____

Prior hospitalizations or surgery: _____

GARDEN STATE CARDIOLOGY
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS



Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____ Date of Birth: _____

I hereby authorize:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

to disclose information from my medical records to

GARDEN STATE CARDIOLOGY
1124 E RIDGEWOOD AVE #202
RIDGEWOOD, NJ 07450 Telephone: 201-689-9400 Fax: 201-689-9404

This information is needed for the following reason: ONGOING MEDICAL CARE

The specific information I wish to have released is (included dates of treatment):

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period.

Signature Date

Expires: _____ Witness: _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

I **DO / DO NOT** consent to have this information disclosed (if present).

Signature Date:

This medical record may contain information concerning HIV testing and / or AIDS diagnosis treatment. Separate consent must be given to release this information.

I **DO / DO NOT** consent to have this information disclosed (if present).

Signature Date



GARDEN STATE CARDIOLOGY

PATIENT SATISFACTION SURVEY

Please rate the services you received from our practice. Circle the number that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for comments. Return the completed survey at check-out or mail back to us at your convenience.

HOW DID YOU DECIDE TO SEEK CARE HERE?

- Location
 Referred by patient
 Referred by doctor
 Referred by Valley
 From insurance book

ACCESS TO CARE

	POOR	FAIR	GOOD	EXCELLENT
1. Ability of getting a convenient appointment	1	2	3	4
2. Courtesy and helpfulness of the scheduler	1	2	3	4
3. Our promptness in returning your phone calls	1	2	3	4

DURING YOUR VISIT

	POOR	FAIR	GOOD	EXCELLENT
1. Speed of the registration process	1	2	3	4
2. Comfort and pleasantness of the reception area	1	2	3	4
3. Waiting time before going to an exam room	1	2	3	4
4. Comfort and cleanliness of the exam room	1	2	3	4
5. Friendliness and courtesy of the medical assistant	1	2	3	4
6. Concern shown by the medical assistant	1	2	3	4
7. Waiting time in exam room before seeing physician	1	2	3	4

YOUR PHYSICIAN

- Dr. Michael Kesselbrenner
 Dr. Robert Saporito
 Dr. Alan Simon

	POOR	FAIR	GOOD	EXCELLENT
1. Friendliness and courtesy of the physician	1	2	3	4
2. Explanation the physician gave you about your condition	1	2	3	4
3. Concern the physician showed for your questions	1	2	3	4
4. Information the physician gave you about medications	1	2	3	4
5. Amount of time the physician spent with you	1	2	3	4
6. Your confidence in this physician	1	2	3	4
7. Likelihood of your recommending this physician to others	1	2	3	4

INSURANCE AND BILLING

	POOR	FAIR	GOOD	EXCELLENT
1. Clarity and accuracy of billing statements	1	2	3	4
2. Our assistance with your insurance or bill questions	1	2	3	4

OVERALL ASSESSMENT

	POOR	FAIR	GOOD	EXCELLENT
1. Attitude of receptionists	1	2	3	4
2. Attitude of medical assistant and technicians	1	2	3	4
3. Attitude of billing staff	1	2	3	4
4. Attitude of physician	1	2	3	4
5. Quality of care provided	1	2	3	4
6. Overall impression of visit	1	2	3	4

COMMENTS

WOULD YOU RECOMMEND THIS PRACTICE TO OTHERS? YES___ NO___

(OPTIONAL) Name:_____

Phone: ()_____