PEDIATRIC CARDIOLOGY OF LONG ISLAND, P.C.

100 PORT WASHINGTON BOULEVARD, ROSLYN, NY 11576 516-365-3340 - FAX: 516-365-5512
232 BARNUM AVENUE, PORT JEFFERSON, NY 11777 631-331-5014
400 WEST MAIN STREET, BABYLON, NY 11702 631-669-9624
70 C OLD RIVERHEAD ROAD, WESTHAMPTON BEACH, NY 516-365-3340

CHART #:_____

PATIENT'S NAME:_____
LAST FIRST M.I.

DATE OF BIRTH:_____ SEX:_____

MARITAL STATUS:_____

PATIENT'S STREET ADDRESS: _____

CITY, STATE:_____ ZIP CODE:_____

HOME PHONE: _____CELL PHONE:_____

ALTERNATE PHONE:_____

EMPLOYER INFORMATION:

NAME OF EMPLOYER:_____

ADDRESS: _____

CITY, STATE:_____ ZIP CODE:_____

SPOUSE/EMERGENCY CONTACT INFORMATION:

NAME:_____
LAST FIRST M.I.

DATE OF BIRTH_____

ADDRESS: _____

CITY, STATE:_____ ZIP CODE:_____

HOME PHONE: _____CELL PHONE:_____

ALTERNATE PHONE:_____

Authorized for release of Information

I hereby authorize and direct the above named clinical practice, having treated me/my dependent, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representative thereof to examine and make copies of all records relating to such care and treatment.

I hereby assign, transfer, and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my or my dependent's medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

_____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

INSURANCE INFORMATION:

PRIMARY:

INSURANCE COMPANY NAME:_____

ID NUMBER:_____ PHONE NUMBER:_____

NAME OF POLICY HOLDER:_____ DOB:_____

ADDRESS:_____

RELATIONSHIP TO POLICY HOLDER:_____

SECONDARY:

INSURANCE COMPANY NAME:_____

ID NUMBER:_____ PHONE NUMBER:_____

NAME OF POLICY HOLDER:_____ DOB:_____

ADDRESS:_____

RELATIONSHIP TO POLICY HOLDER:_____

PLEASE NOTE: MANAGED CARE INSURANCE REQUIRES REFERRAL TO SPECIALIST BY THE PRIMARY CARE PHYSICIAN, EITHER IN WRITING OR BY AUTHORIZATION NUMBER, ACCORDING TO THE POLICY. IF SUCH REFERRAL IS NOT PROVIDED, PARENT, LEGAL GUARDIAN OR GUARANTOR MAY BE RESPONSIBLE FOR PAYMENT.

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_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

PLEASE LIST ANY DOCTORS THAT WILL REQUIRE THE RESULTS FROM THIS CARDIOLOGY VISIT. CONSULTATION LETTERS WILL BE MAILED TO THE DOCTORS WRITTEN BELOW. CONSULTATION LETTERS WILL BE SENT WITHIN TEN BUSINESS DAYS FROM THE DATE OF SERVICE.

ANY MEDICAL, DENTAL OR SPORTS CLEARANCES SHOULD BE REQUESTED DURING THE VISIT OR THERE MIGHT BE AN ADDITIONAL CHARGE.

PRIMARY CARE PHYSICIAN:

NAME:_____

ADDRESS:_____

CITY:_____ STATE_____ ZIP:_____

PHONE:_____

ADDITIONAL DOCTORS:

NAME/TYPE OF PHYSICIAN:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE:_____

NAME/TYPE OF PHYSICIAN:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE:_____

NAME/TYPE OF PHYSICIAN:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE:_____

_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

OUR OFFICE POLICIES

MEDICAL RECORDS

All requests for medical records must be in writing. If the patient is 18 years or older, the request must be completed and signed by the patient. Upon receiving the written request, the records may be available within ten business days. Depending how old the records are, it may take up to one month for availability.

Additionally, there is a 75¢ charge per page after six pages. If records are being sent to another physician or hospital, we will extend a courtesy and no fee will be charged. Records over six pages will not be faxed, instead they will be mailed.

For any forms, letters or other paperwork outside routine medical care there will be an additional charge depending on the complexity.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

OUR OFFICE POLICIES

We appreciate your confidence in choosing Pediatric Cardiology of Long Island. Please take a moment to review our office financial policy below. We have also included a copy for you to take home.

CO-PAYMENTS:

If you are an enrolled in a managed care plan which we are contracted, you are required to pay the specialist co-payment each time you are seen. This must be paid prior to being seen. If you are not prepared at the time of service, there will be a $25.00 surcharge imposed.

CO-INSURANCE:

In addition to the co-payments and deductibles, some plans have a co-insurance. This is a percentage of the reimbursement amount that you and your insurance company have agreed upon. It is YOUR responsibility to know your co-insurance prior to being seen. In the event that there is a balance after the insurance carrier has paid its portion, our office will bill you.

DEDUCTIBLE:

In addition to co-payments and co-insurances, some plans have an annual deductible. This can either be an individual deductible or a family deductible. It is YOUR responsibility to know the amount of your deductible and whether or not it has been met, prior to your visit. In the event that there is a balance after the insurance carrier has paid its portion, our office will bill you.

IT IS THE RESPONSIBILITY OF THE PATIENT OR POLICY HOLDER TO BE FAMILIAR WITH THEIR INSURANCE POLICY. IT IS IMPOSSIBLE TO GET ANY GUARANTEE OF PAYMENT UNTIL A CLAIM IS SUBMITTED. THEREFORE, THE PATIENT/PARENT/ GUARDIAN IS LIABLE FOR ANY CHARGES THAT ARE NOT COVERED UNDER THEIR CONTRACT.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR CO-INSURANCE AND DEDUCTIBLE PRIOR TO BEING SEEN.
OUR STAFF WILL NOT INFORM YOU OF THESE RESPONSIBILITIES.

It is our office policy to send three bills. After 90 days your account will incur finance charges every month, for which you are responsible. Your final statement will advise you that the balance will be turned over to a collection agency. You will be responsible for the insurance balance, finance charges and any costs which may result from collection proceedings. To avoid this, please pay your bill promptly. If you do not understand the reason for the balance, please do not hesitate to contact our office. We are always willing to set up a payment plan.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

FINANCIAL WAIVER

In consideration of services rendered by your physician at Pediatric Cardiology of Long Island to the undersigned patient, the undersigned promise(s) to pay Pediatric Cardiology of Long Island any co-payment, co-insurance, deductible or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services/procedures (i.e.: pulse ox, ekg, echo, etc.) that are not covered by my health insurance plan.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF
Pediatric Cardiology of Long Island

RECEIPT OF NOTICE OF PRIVACY PRACTICES

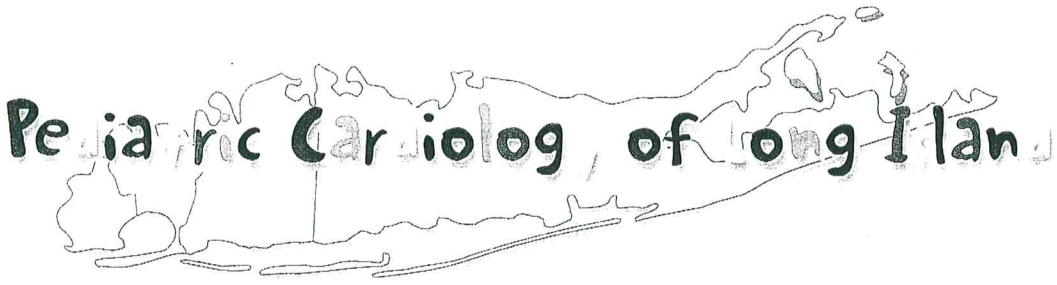
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have reviewed a copy of Pediatric Cardiology of Long Island's Notice of Privacy Practices.

I,_____am over 18 years old and give permission for any test results and health information to be shared with

_____who is my_____

Thank You.



Staff Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____