Willowbrook Cardiovascular Associates

Nadim Nasir Jr, MD, FACC
Valentina Ugolini, MD, FACC
Anton Nielsen, MD, FACC
Stanley Duchman, MD
John Isaac, MD, FACC
Tapan Rami, MD, FACC
Douglas Bree, MD, FACC

Patient Information

FIRST NAME:	MI:	LAST:
ADDRESS:		
SOCIAL SECURITY #:		HOME PHONE #:
DATE OF BIRTH:		MARITAL STATUS:
OCCUPATION:		EMPLOYER:
MOBILE PHONE #:		WORK PHONE #:

EMERGENCY CONTACT:	
(NEAREST FRIEND OR RELATIVE NOT LIVING IN THE SAME HOUSEHOLD)	
RELATIONSHIP:	PHONE#:

IF MARRIED, PLEASE COMPLETE SPOUSE'S INFORMATION.	IF DEPENDENT, PLEASE COMPLETE (PARENTS INFORMATION)
SPOUSE'S / PARENT'S NAME:	EMPLOYER'S NAME:
SOCIAL SECURITY #:	WORK PHONE #:
DATE OF BIRTH:	MOBILE PHONE #:

RESPONSIBLE PARTY OR POLICY HOLDER (PLEASE CHECK ONE): SELF _____ SPOUSE _____ PARENT _____	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
INSURANCE PHONE#:	INSURANCE PHONE#:
POLICY ID #:	POLICY ID #:
GROUP #:	GROUP #:

REFERRING PHYSICIAN:	OFFICE PHONE #:
PRIMARY CARE PHYSICIAN:	OFFICE PHONE #:

WILL THIS CLAIM BE COVERED UNDER WORKER'S COMPENSATION? YES _____ NO _____	
IF YES, NAME AND ADDRESS OF COMPANY	
PHONE #:	TREATMENT AUTHORIZED BY:

I HEREBY CONSENT TO MEDICAL SERVICES AND TREATMENT FROM THE PHYSICIANS AND STAFF OF WILLOWBROOK CARDIOVASCULAR ASSOCIATES (WCA). I AUTHORIZE WCV TO RELEASE ANY AND ALL INFORMATION TO CONSULTING PHYSICIAN'S) AND TO MY INSURANCE COMPANY(IES) FOR PROCESSING OF MY INSURANCE CLAIMS. I ASSIGN ALL INSURANCE BENEFITS PAYABLE FOR SERVICES RENDERED TO ME OR MY DEPENDENTS AND AUTHORIZE DIRECT PAYMENT TO WCV. I UNDERSTAND THAT PAYMENT FOR ALL SERVICES IS MY ULTIMATE RESPONSIBILITY.

Signature of Patient or Responsible Party (Parent/Guardian) & Relationship **Date**

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health care Operations

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatments, and any plans for future care of treatment. I understand that this information serves as:

* A basis for planning my care and treatment
* A means for communication among many health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third-party payer can verify that services billed were actually provided
* And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Accept _____ Deny _____

_____

Signature of Patient or Responsible Party (Parent/Guardian) & Relationship **Date**

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Financial Policy and Informed Consent

Willowbrook Cardiovascualr Associates (WCA) is committed to your treatment being successful. Please understand payment of your bill is your responsibility. In order to reduce confusion and misunderstanding between our patients and WCA we have adopted the following financial policy, which we require you to read and sign below. Unless prior arrangements have been made, FULL payment is due at the time of service. We accept cash, check, and credit cards.

Regarding Insurances

We have made arrangements with many insurance carriers and other health plans to accept assignment of benefits. WCA will bill those plans whom we have an agreement. Co-payments, deductibles, coinsurances are due at the time of service if required by the plan.

Regarding Medicare

If you have Medicare, the deductible and the 20% coinsurance, when applicable, are due at the time of services.

Regarding Usual and Customary or Not Covered

Our practice is committed to providing the best treatment for the best treatment for our patients and we charge what is usual and customary in our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates or what is "not cover" services. Payment is due upon receipt of a statement from our office.

Regarding Referrals

In the event your insurance company requires a referral from your primary care physicians (PCP) and you arrive for appointment without an authorized referral, or and incorrect referral, you will be responsible for the complete charges or you may reschedule your appointment. Payment is due upon receipt of a statement from our office.

Regarding Hospital Services

We will bill your health plan for all services provided in the hospital. Any balance due is your responsability and is due upon receipt of a statement from our office.

Regarding Minor Patients

For all services rendered to a minor or dependent patient, WCA will request the parent and/or guardian to be responsible for all payments.

Financial Policy

I have read and understand the financial policy of WCA, and I agree to be bound by its terms. I understand and agree that such terms may be amended from time to time by the practice.

Informed Consent

I have reviewed the Registration Summary and correct/updated information where appropriate. I hereby consent to medical services and treatment from the physicians and staff of WCA and authorize WCA to release any and all informa- tion to consulting physician and insurance company(ies) for claims processing.

Signature of Patient or Responsible Party (Parent/Guardian) & Relationship **Date**

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME:		
ADDRESS:		
SOCIAL SECURITY #:	PHONE #:	DATE OF BIRTH:

I HEREBY AUTHORIZE WILLOWBROOK CARDIOVASCULAR ASSOCIATES TO RELEASE TO: _____ RECEIVE FROM:_____

NAME OF PERSON OR ORGANIZATION

ADDRESS

PHONE # FAX #

THE MEDICAL RECORDS OF: (PATIENT'S NAME)

FOR THE DATE(S) OF:

FOR THE FOLLOWING PURPOSE(S): MEDICAL: _____ LEGAL: _____ INSURANCE: _____ OTHER: _____

SELECT PORTIONS		
____ History and Physical	____ Radiology/Imaging Report(s)	____ Operative/Procedure Reports
____ Discharge Summary	____ Radiology/Imaging Films	____ Cath Lab Report(s) w/ Diagram
____ Consultations	____ Psychiatric Report(s)/Information	____ Labs
____ Operative/Procedure Report(s)	____ Pathology Report(s)	____ ALL Medical Records
____ Electrocardiogram &/or EKG	____ HIV Test Results	____ Nursing Notes
____ Holter Monitor Report(s)	____ AIDS Information	____ MD Progress Notes
____ Nuclear Stress Test Report(s)	____ Billing Records	____ MD Orders
____other Cardiac Studies	____ Itemized Bill	____ Face Sheet
____ Drug/ Alcohol Information		

This authorization is valid until the 180th day after the date it is signed unless specified in writing, not to be exceeded 24 months, or unless it is reviewed (except to the extent that action has been taken in reliance on it), and covers only treatment's) for the dates specified above. I understand that when this information is used or disclosed pursuant to this authorization, it amy be subject to re-disclosure by the recient and longer be protected. I hereby release and hold harmless WCA from all liability and damages resulting from the faithful release of my Protested Health Information.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by Federal Law. If so, Federal regulations (42 CFR Part2) prohibits you from making any further disclosure of it without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

Signature of Patient or Responsible Party (Parent/Guardian) & Relationship **Date**