Interboro Surgical Associates, P.C.

Cardiothoracic & Vascular Surgery

PAYMENT POLICY STATEMENT

Welcome to Interboro Surgical Associates. The following is a statement of our financial policy. We hope this gives you a better understanding of our billing practice. Patients cared for by our practice come with different insurance and payment options. Please understand that physicians in this practice **do not accept** the same insurance types.

PARTICIPATING PROVIDERS: This means that the physician you will see accepts your insurance.

- **Please present insurance cards when requested, as well as any referrals if required.**
- **COPAYMENTS ARE DUE AT TIME OF SERVICE, PLEASE REMEMBER TO CHECK OUT AT THE FRONT DESK AFTER YOUR VISIT.**
- **The patient or guarantor will be held responsible for any deductibles, co-insurance, or any other financial obligations dictated by your insurance contract. It is the patient's responsibility to know the terms of their insurance contract.**
- **The patient acknowledges that any charge not covered by their insurance is their financial responsibility.**
- **Patients without insurance card(s) and valid referrals may be asked for payment in full at time of service if their insurance can not be verified.**

NON-PARTICIPATING PROVIDERS: This means that the physician you will see does not accept you insurance.

PAYMENT FOR ALL SERVICES RELATED TO THE VISIT IS DUE AT TIME OF SERVICE. You will be provided with a receipt for you to submit to your insurance. Please be aware of what you contract is with your insurance. If you do not have out of network benefits you will not be eligible for reimbursement from your insurance company.

The following methods of payment are provided for your convenience:

- Cash
- Checks
- All major credit cards (Visa, MasterCard, American Express, Discover)

I have read the payment policy; I fully understand and agree to it.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

DEMOGRAPHICS: Please complete this form in its entirety.

First Name: _____ Last Name: _____ D.O.B: _____

Age: _____ Sex: M F Marital Status: Married Single Divorced Widowed

Address: _____ Apt _____

City: _____ State _____ Zip _____

Primary Language Spoken: _____ Interpreter Needed: Yes No

Social Security Number: _____-_____-_____

CONTACT INFORMATION:

Home Tel: ( ) _____-_____ Work Tel: ( ) _____-_____

Cell Phone: ( ) _____-_____ Fax: ( ) _____-_____

Other Tel: ( ) _____-_____ Email: _____@_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Home Tel: ( ) _____-_____ Cell Phone: ( ) _____-_____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy ID # _____

Secondary Insurance: _____ Policy ID # _____

PERSONAL/SOCIAL HISTORY: Please answer **YES** or **NO** to the following questions and explain where needed.

Do you have children?	**YES**	**NO**	
Do you live alone?	**YES**	**NO**	
Are you retired?	**YES**	**NO**	
Are you employed	**YES**	**NO**	What is your Occupation: _____
Do you smoke?	**YES**	**NO**	If so how often? _____
			If you quit when? _____
Occupational hazards?	**YES**	**NO**	If so, what? _____
Exposure to asbestos?	**YES**	**NO**	If so, when? _____
Do you drink?	**YES**	**NO**	If so how often? _____
Do you exercise regularly?	**YES**	**NO**	If so how often? _____
Is your weight stable?	**YES**	**NO**	
Do you need help caring for yourself?	**YES**	**NO**	

Signature: _____ **Date:** _____

PLEASE DO NOT LEAVE BLANK.

Primary Care Physician (PCP/Internist): Check this box if this physician referred you. ☐

Name: _____ Tel: ( ) _____-_____

Address: _____ Last office visit: _____

Cardiologist): Check this box if this physician referred you. ☐

Name: _____ Tel: ( ) _____-_____

Address: _____Last office visit: _____

Oncologist/Hematologist: Check this box if this physician referred you. ☐

Name: _____ Tel: ( ) _____-_____

Address: _____Last office visit: _____

Pulmonologist: Check this box if this physician referred you. ☐

Name: _____ Tel: ( ) _____-_____

Address: _____Last office visit: _____

Neurologist: Check this box if this physician referred you. ☐

Name: _____ Tel: ( ) _____-_____

Address: _____Last office visit: _____

Gastroenterologist: Check this box if this physician referred you. ☐

Name: _____ Tel: ( ) _____-_____

Address: _____Last office visit: _____

Gynecologist: Check this box if this physician referred you. ☐

Name: _____ Tel: ( ) _____-_____

Address: _____Last office visit: _____

Other Physician: Check this box if this physician referred you. ☐

Name: _____ Tel: ( ) _____-_____

Address: _____Last office visit: _____

CURRENT SYMPTOMS (PLEASE DO NOT LEAVE EMPTY): _____

_____

_____

MEDICATIONS:

Please list all the medications you are currently taking (including any homeopathic medications and vitamins).

Medication	Dosage & Frequency		Medication	Dosage & Frequency

ALLERGIES: Please list all possible allergic reactions

Allergy	Type of Reaction		Allergy	Type of Reaction

SURGICAL HISTORY: List all previous surgeries **MEDICAL CONDITIONS:** list all medical conditions

Surgical History	When		Medical Condition	Date of Onset

Do you have any implanted devices: **YES** **NO** If so what? _____

_____

Please present your device identification card to the front desk.

FAMILY HISTORY: Please check the box if you have a family history of any of the following.

YES **NO** Aneurysm
YES **NO** Cancer
YES **NO** Diabetes
YES **NO** Heart Attack
YES **NO** Stroke
YES **NO** None of the Above
YES **NO** Other _____

MEDICAL HISTORY: Please answer YES or NO for the following and explain where applicable.

Have you ever had or have been treated for any of the following:

PLEASE DO NOT LEAVE BLANK.

YES NO Asthma
YES NO Bleeding or bruising tendency
YES NO Breathing problems
YES NO Burning/numbness in hands/feet
YES NO Cancer What type & When:

_____

YES NO Catheterization of your heart
Date:_____
YES NO Chemotherapy/Radiation
Date: _____
YES NO Chest Pains
YES NO Clotting tendency/Phlebitis
YES NO Collagen disease
YES NO Constipation
YES NO Diabetes
YES NO Diarrhea
YES NO Difficulty walking
YES NO Diverticulitis
YES NO Embolus or lung clots
YES NO Gallbladder problems
YES NO Heart attack – Date: _____
YES NO Heart failure
YES NO Heart stress test - Date: _____
YES NO Heart surgery – Date: _____
YES NO Hepatitis
YES NO High blood pressure
YES NO High cholesterol
YES NO Intestinal bleeding
YES NO Irregular heartbeats/palpitations
YES NO Kidney disease
YES NO Loss of appetite within past year
YES NO Mitral valve prolapse
YES NO Nausea
YES NO Pain or problems with urination
YES NO Problems with anesthesia
YES NO Shortness of breath with exertion
YES NO Sleep Apnea
YES NO Steroid Treatment
YES NO Stroke – Date: _____
YES NO Swelling – Describe: _____

_____

YES NO Thyroid disease
YES NO Trouble urinating
YES NO Vomiting
YES NO Weight loss

Vital Signs

BP _____/_____ Weight _____ Height _____ Temp _____ Pulse _____ Resp _____

Patient Signature: _____ Date: _____

Authorization To Use or Disclose Health Information

Patient Name: _____ MRN#: _____
Street: _____ DOB: _____
City: _____ Phone: _____
ST: _____ Zip: _____ Healthquest #: _____

I authorize the release of the following health information:

Entire medical record Date(s): _____
Diagnostic Tests Date(s): _____
Doctor's Notes (from Dr._____) Date(s): _____
Lab Results Date(s): _____
Pathology Reports ____ Specimens____ Date(s): _____
Radiology Reports ____ Images ____ Date(s): _____
Medical Record/Information from outside the institution brought to the practice by me (explain):

_____

All of the above with the exception of: _____
Other: _____

Who will receive information:

Interboro Surgical Associates, P.C.
8318 4th Avenue
Brooklyn, NY 11209

This authorization expires: ( ) specific time frame _____, ( ) when record is received, ( ) other (explain)

_____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care
- I may revoke this authorization at any time before the information I have requested is released by completing a "Request to Revoke An Authorization" form, which is available at this office
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Interboro Surgical Associates, P.C. shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatry notes, state or federal regulations may have additional compliance requirements
- I may request a copy of this signed form
- Interboro Surgical Associates, P.C. may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor's office will inform me of any charges and arrange for payment

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient

Insurance Authorization

I request that payment of authorized Medicare benefits be made DIRECTLY to the above mentioned company, and/or physicians for services furnished to be by that physician. I authorize any Health Care Financing Administration and its agents to access any information needed to determine these benefit(s) payable for related services. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE MEDICAL FORM.

PLEASE NOTE:
MEDICINE ASSIGNMENT MEANS THAT WE ACCEPT THE MEDICARE APPROVED AMOUNT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR THE 20% CO-INSURANCE AND/OR DEDUCTIBLE. SUPPLEMENTAL INSURANCE MAY PICK UP THE CO-INSURANCE.

Signature of Beneficiary: _____ Date: _____

COMMERCIAL INSURANCE:

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN benefits directly to the about mentioned company, and/or physicians. I understand that I am financially responsible for all charges whether or not paid by the insurance company.

I authorize the use of this signature on all my insurance claim submissions

Signature of Patient: _____ Date: _____

Interboro Surgical Associates
8318 4th Avenue
Brooklyn, NY 11209

HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Interboro Surgical Associates, P.C. and its employees, and how I may obtain access to and control this information.

_____ _____

Print Patient Name Date

_____

Parent or Authorized Representative

_____

Patient Signature

Individuals involved in care with which we may share your health information:

Name: _____
Phone: _____
Relation: _____

Name: _____
Phone: _____
Relation: _____