ACI
Advanced Cardiology Institute

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Tel (201) 461-6200
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www.acicardio.com

Dear Patient,

We would like to welcome you as a new patient to our practice. Enclosed are forms that you are required to complete prior to your appointment. These forms include a patient information sheet, a medical records request form (in order to retrieve any pertinent medical records from your previous physician), a HIPAA compliant waiver of consent form and important information about our facility and a medical history form. If another physician referred you, please bring any written referral/prescription or instructions that he/she may have given you. You should bring a detailed list of all of your current medications.

Please fill out the appropriate forms and present them to our receptionist when you arrive in our office. You are also required to present a copy of your insurance card/s and copayment (if applicable). If you have no insurance we ask that payment be made at the time of service. We accept Visa, Mastercard and American Express.

If you have been referred for diagnostic testing or if it is indicated following your initial examination, our facility is equipped to perform the following in our office: exercise stress test, echocardiogram, stress echocardiogram, carotid ultrasound, nuclear imaging, pacemaker interrogation, 24 hour blood pressure monitoring, ankle brachial indexing and holter monitoring.

We look forward to offering you our help and support, and we anticipate providing you with superior quality healthcare.

Sincerely,

Drs. Berkowitz, Rothman, Lebowitz, Hollywood, Zanger, Kim & Krasikov

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FROM THE EAST (*George Washington Bridge*)

Lower Level: Exit 9W Fort Lee Palisades Parkway. Near right onto 9W/Fletcher Avenue. At first light make right into building driveway.

A) Proceed straight toward building and turn right into second parking garage. Park in designated spaces on your left marked "B&R Reserved".

Upper Level: Exit Fort Lee-Lemoine/Center Avenue. At stop sign make wide turn onto Center Avenue.

B) First light make left onto Bridge Plaza North. Pass one light and bear right onto 9W/Fletcher Avenue. At first light make right into building driveway. Follow directions from A above.

FROM THE WEST

Route 4: Exit Fort Lee/Palisades Parkway/9W, 1&9. 46 (at Hilton) follow ramp to light and make a left onto 9W/Fletcher Avenue. At second light make right into building driveway. Follow directions from A above.

Route 80 (local lanes only): Exit Fort Lee/Palisades Parkway/9W, 1&9. 46 (at Hilton) follow ramp to light and make a left onto 9W/Fletcher Avenue. At second light make right into building driveway. Follow directions from A above.

FROM THE SOUTH

Take Anderson Avenue (two way): to Center Avenue (one way). Continue on Center Avenue until intersection of Bridge Plaza North making left and follow directions from B above.

FROM THE NORTH

From Palisades Interstate Parkway (PIP): Take exit 1 Palisade Avenue/Englewood. Exit bearing right. Make left at light onto 9W. Continue straight for 1 ½ miles. 9W bears right before overpass. Continue until second light make left into building driveway. Follow directions from A above.

2200 Fletcher Avenue
Fort Lee, NJ 07024
Phone: (201)461-6200 Fax: (201)461-7204

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List of Participating Insurances

Aetna
Amerihealth
Cigna
Empire New York Blue Shield:
Healthnet
GHI PPO only
Horizon PPO Network (No Medicaid products)
Horizon POS/HMO Network
Horizon Blue Card Network (Out of state Blue Shield plans)
Medicare
Qualcare
Railroad Medicare
Oxford
United Healthcare

We do not participate in any Managed Medicaid products (ie. Americhoice, Horizon NJ Health)

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Patient Information Form

PATIENT INFORMATION

DATE

NAME	M F	DATE OF BIRTH	SOCIAL SECURITY
STREET ADDRESS		CITY STATE, ZIP	PHONE ( )
MARITAL STATUS M S W D		DRIVERS LICENSE #	
TELEPHONE		CELL PHONE	
EMPLOYER'S NAME		EMPLOYER'S PHONE	
BUSINESS ADDRESS			
EMERGENCY CONTACT		RELATIONSHIP	PHONE ( )
PHARMACY			PHONE ( )

INSURANCE INFORMATION

MY INSURANCE IS: ☐ MEDICARE CHECK: ☐ PRIMARY ☐ SECONDARY

☐ HMO ☐ PPO ☐ NONE * (SEE BELOW)

MEDICARE ID: (IF APPLICABLE) EFF. DATE

MY HMO INSURANCE COMPANY REQUIRES A REFERRAL ☐YES ☐NO (PLEASE HAND ANY REFERRALS IN WITH THIS FORM)

PRIMARY INSURANCE CARRIER OR MEDICARE SUPPLEMENTAL INFORMATION

INSURANCE COMPANY	I.D. #	EFFECTIVE DATE
SUBSCRIBER'S NAME		SS#
RELATIONSHIP TO PATIENT	I.D. #	DOB

I HAVE NO INSURANCE AND/OR OVERSEAS INSURANCE AND CHOOSE TO PAY WITH A CREDIT CARD.

☐ VISA ☐ MASTER CARD ☐ AMERICAN EXPRESS CREDIT CARD NUMBER: EXP. DATE

PATIENT AUTHORIZATION

I hereby authorize Drs. Berkowitz, Rothman, Lebowitz, Hollywood, Zanger, Kim and Krasikov to furnish information to insurance carriers concerning my illness and treatments. I accept all responsibility to pay for non-covered services by my insurance company. If I belong to a plan in which the doctors participate I accept liability to pay for any co-pay, deductible and/or any other services which are determined to be my responsibility. If my plan requires any laboratory work to be processed by a specific facility, it is my responsibility to inform the staff.

I hereby assign to the physicians all payments for medical services rendered to myself or my dependents when billed as such by the doctors office. If I have no insurance coverage I accept liability to pay in full for services rendered. If I do not supply a referral (if applicable), I understand that my insurance carrier may pay as out of network or not pay at all in which case I will be liable for the charges.

PATIENT NAME *(please print)* .... DATE ....

I have read and fully understand the information contained in this notice and agree to comply with its contents as they have been explained.

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Patient History Information

PATIENT NAME DOB DATE

Please check Y yes or N no, circle or explain where required. N/A-Not Applicable

Reason for today's visit: **Referring Physician:**

MEDICAL HISTORY

Have you had any of the following? Please check the appropriate box below:

Diabetes	Y N	Stroke	Y N	Cancer	Y N
Hypertension	Y N	Palpitations	Y N	German measles (3 day)	Y N
Bleeding Disorder	Y N	High Cholesterol	Y N		
Chest Pain	Y N	Shortness of Breath	Y N		
Pacemaker/Defib.	Y N	Excessive sweating	Y N		

Surgeries (if yes dates/explain) Y N

Surgeries (if yes dates/explain)

MEDICATION

Medication Name	Strength	Frequency	Date Started

Vaccine		Date
Flu	Y N	
Pneumonia	Y N	
Other	Y N	

CARDIAC TESTING

		Year	Positive	Negative
Exercise Stress Test	Y N		☐	☐
Nuclear Stress Test	Y N		☐	☐
Echocardiogram	Y N		☐	☐
Stress Echocardiogram	Y N		☐	☐
Carotid Ultrasound	Y N		☐	☐
Ankle Brachial Indexing	Y N		☐	☐
Holter Monitor	Y N		☐	☐
24 Hour BP Monitor	Y N		☐	☐

SOCIAL HISTORY

Check appropriate box. If yes please provide further information.

Allergies/Reaction	Y N	
Smoker (Prior/Present Yrs.)	Y N	
Drink Alcohol	Y N	
Use Illicit Drugs	Y N	
Exercise (How Often)	Y N	
Coffee/Tea (Cups per Day)	Y N	
Married/Divorced/Single	Y N	
Pregnancies/Children	Y N	
Last Menstrual Period	Y N	
Tuberculosis	Y N	
Arthritis	Y N	
Epilepsy / Seizures	Y N	
Heart Disease	Y N	
High Blood Pressure	Y N	
Cholesterol Problem	Y N	
Migraine	Y N	
Sudden Infant Death	Y N	
Birth Defects	Y N	
Early Deafness	Y N	
Diabetes	Y N	

FAMILY HISTORY

Father	☐ Deceased	☐ Alive & Well	Age
Mother	☐ Deceased	☐ Alive & Well	Age
Brother	☐ Deceased	☐ Alive & Well	Age
Sister	☐ Deceased	☐ Alive & Well	Age
Son	☐ Deceased	☐ Alive & Well	Age
Daughter	☐ Deceased	☐ Alive & Well	Age

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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Physician/Patient Agreement, which we require you to read and sign prior to any treatment. Please be advised that we outsource our billing to Millennium Practice Management. All patients must complete our Patient Information form and provide current copies of their insurance cards before seeing the doctor.

- **WE ACCEPT CASH, CHECKS, VISA/MASTERCARD AND AMERICAN EXPRESS.**

Participating Plans

If in the event that we participate in your Managed Care, Preferred Provider, or Blue Shield plan…all co-pays and deductibles are due prior to treatment. You must present a referral if your plan requires you to do so. If you come to your appointment without your referral, you can reschedule that appointment for another day or pay for your services in full prior to being seen. If at any time your coverage changes to an indemnity or traditional insurance plan, please refer to the above paragraph.

Changes in Insurance

Please notify the staff of any changes in your coverage before you are seen for your appointment. We cannot be responsible for any laboratory specimens being routed to the wrong laboratory if we do not have up to date information.

Regarding Medicare

This office accepts assignment on Medicare claims. We will provide you with a brochure that clearly explains your Medicare Benefits. We will submit for secondary insurance plans that we are participating providers in, otherwise, we ask that you contact your secondary insurer and inquire about a crossover agreement with Medicare, as, we will not submit for any secondary insurance plans that do not extend this courtesy.

Regarding Non-Participating Insurance

FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

If we are not participating in your insurance, we will require 100% of the bill to be paid at the time that services are rendered with no exception. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you supply us with accurate and up to date insurance information and/or an original claim form. Your private insurance plan is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, we require that you be pre-approved on our extended payment plan or provide us with a credit card authorization to bill that account for the balance. If your insurance company fails to pay your account in full within 45 days, the balance will be transferred to your credit card or to the extended payment plan. Please be aware that some, or perhaps all, of the services provided to you may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or medical insurance.

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I understand that this office DOES NOT participate with my health insurance plan and I will be responsible for any and all charges not paid by them. __________________ (Initial)

Usual and Customary Rates

Our practice strives to provide the best treatment available for you, our patient. We charge what is reasonable and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Privacy and Release of Medical Information

Please be aware that we will not release information of a medical nature to anyone but you, the patient, unless you provide us written permission to do otherwise. However, in the event that your insurance company requires us to release medical information to pay a claim, this agreement will allow us to release the requested information.

Non-Payment and Assignment to Collection Agency

We offer flexible payment arrangements and want to help you settle any balances that are your responsibility in a prompt manner. If you are experiencing difficulty in paying your bill, it is your responsibility to contact the billing office to resolve your issue. Overdue patient and insurance balances may be submitted for collections activity after 90 days of non-payment. Please be aware that any account that is assigned for collect ion activity cannot be "removed" from collections once it has been placed with our agent.

____
Signature of the Patient or Responsible Party

____
Date

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Name:______________________________DOB:________________SSN:_________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare 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.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- 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.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

❑ I DO NOT WANT INFORMATION RELEASED TO THE FOLLOWING PEOPLE:

____

____

I have read the above notice of privacy and give consent to Drs. Berkowitz, Rothman, Lebowitz, Hollywood, Zanger, Kim and Krasikov and their staff to: (Please Check 1, 2 or 3)

❑ 1. Leave detailed messages on my home answering machine and/or with other members of my household.

❑ 2. Contact me at my place of employment for the purpose of confirming appointments and/or returning phone calls.

❑ 3. Contact me on my cell phone and/or leave message on my cell phone.

____________________________________ _________ _____________________________

Signature of Patient or Legal Representative **Date** **Witness Signature**