New Brunswick Cardiology Group, P.A. | RWJBarnabas HEALTH

Anand U. Kulkarni, M.D., FACC
Clifford D. Gladstone, M.D., FACC, RPVI
Sheldon J. Kukafka, M.D., FACC
Subhashini A. Gowda, M.D., FACC
Pravien K. Khanna, M.D., MPH, FACC, FSCAI
Rashesh Shah, M.D., FACC

Name _____ Date_____

Appointment Date_____Time_____Physician_____Location_____

Welcome to New Brunswick Cardiology Group-RWJBarnabas Health

Please complete the enclosed forms and give them to our Patient Service Rep upon arrival.

- Patient Information form
- Health History Form
- Release of Medical Record Form

You are required to arrive 30 minutes prior to your appointment time so we may complete your electronic health and financial records or your appointment will be cancelled.

- Most **recent EKG and other cardiac related reports**
- **Prescription medication in their containers**
- **Letter requesting a consult** if being sent to NBCG for a cardiology consult
- **Health insurance ID card(s)**
- A valid **photo ID/**driver's license
- **Referral** from your primary physician if required by your health insurance carrier
- **Co-pay** if required by your health insurance carrier. NBCG accepts cash, credit cards, debit cards and personal checks.

If you have any questions, please do not hesitate to call us and speak with a Receptionist.

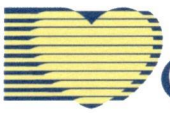
Our website, www.nbcardiology.com, has extensive information about the physicians and the practice as well as directions to our three offices.

Thank you for choosing New Brunswick Cardiology Group-RWJBarnabas Health. We look forward to meeting you and the opportunity to provide the highest quality cardiology care possible.

Sincerely,

The Physicians and Staff of New Brunswick Cardiology Group-RWJBarnabas Health

6/6/2022 djh



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RWJBarnabas HEALTH

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name: _____ Birthdate: _____ Patient #: _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal versus abnormal color, activity, etc.)

Severity: _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration: _____
(How long have you had this pain/problem? or, When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms: _____
(What other associated problems have you been having?)

Modifying factors: _____
(What makes the pain/problem worse or better? or Have you had previous episodes?)

Past Medical History - Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no yes	Anemia	/no yes	Back Trouble	no yes	Hepatitis	no yes
Mumps	no yes	Bladder Infections	no yes	High Blood Pressure	no yes	Ulcer	no yes
Chickenpox	no yes	Epilepsy	no yes	Low Blood Pressure	no yes	Kidney Disease	no yes
Whooping cough	no yes	Migraine Headaches	no yes	Hemorrhoids	no yes	Thyroid Disease	no yes
Scarlet Fever	no yes	Tuberculosis	no yes	Date of last chest x-ray _____		Bleeding Tendency	no yes
Diphtheria	no yes	Diabetes	no yes	Asthma	no yes	Any other disease	no yes
Smallpox	no yes	Cancer	no yes	Hives or Eczema	no yes	(please list):	
Pneumonia	no yes	Polio	no yes	AIDS or HIV+	no yes	_____	
Rheumatic Fever	no yes	Glaucoma	no yes	Infectious Mono	no yes	_____	
Heart Disease	no yes	Hernia	no yes	Bronchitis	no yes		
Arthritis	no yes	Blood or Plasma		Mitral Valve Prolapse	no yes	_____	
Venereal Disease	no yes	Transfusions	no yes	Stroke	no yes		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

Medications: (Include Nonprescription):

_____

_____

Have you ever taken Fen-Phen/Redux? no yes

Patient Social History:

Marital status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____ Domestic Partner ____

Use of alcohol: Never ____ Rarely ____ Moderate ____ Daily ____

Use of tobacco: Never ____ Previously, but quit ____ Current packs/day ____

Use of drugs: Never ____ Type/frequency _____

Excessive exposure at home or work to: Fumes ____ Dust ____ Solvents ____ Air-borne Particles ____ Noise ____

Family medical history:

	Age	Diseases	If deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____
	____	_____	_____

Patient Name_____Date of Birth_____

Allergic/Immunologic

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol or other Narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications_____

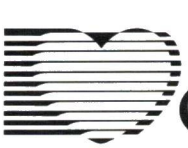
Known food allergies_____

Environmental allergies_____

Acknowledgement of Medical Information herein: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my health. It is my responsibility to inform the physician's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature:_____Date_____

Signature of Patient, Parent or Guardian Required.



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Patient Information

Last Name: _____ First Name: _____ M I: _____ Maiden or Nickname: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Home Phone Number: (_____)_____ Work Phone Number (_____)_____ Ext: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed Sex: ___ M ___ F Cell Phone Number: (_____)_____

Insurance Information – Primary / Secondary / Other

***** Please Give Your Insurance Cards To The Receptionist *****

Is this office visit related to a Workman's Compensation case? ___ Y ___ N or Motor vehicle accident? ___ Y ___ N

Do you have health insurance? ___ Y ___ N Copay? ___ Y ___ N Amount $_____

Primary Insurance _____ Address _____

Policy Number _____ Group Number _____ Please indicate the policyholder for the primary insurance: ___ Self ___ Spouse

Secondary Insurance _____ Address _____

Policy Number _____ Group Number _____ Please indicate the policyholder for the secondary insurance: ___ Self ___ Spouse

Patient's Employer Information

Employer's Name _____ Patient's Occupation _____

Address _____ Telephone Number _____

City: _____ State: _____ Zip: _____

Spouse's Information (If Patient is covered by Spouse's Insurance)

Spouse's Name _____ Spouse's Birth Date _____

Spouse's Social Security Number _____ Employers Phone Number (_____)_____

Spouse's Employer _____

Spouse's Employer's Address _____ State _____ Zip _____

Emergency Information

Please list the nearest living relative/friend other than your spouse

In case of an emergency, we may contact: _____

Phone Number (_____)_____ Relationship to Patient _____

Primary Care Physician Information

Your Primary Care Physician's Name: _____ Telephone Number (_____)_____

Address _____ Release Information to PCP? _____ Y _____ N

ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION

I certify that the information provided herein is correct and accurate and hereby authorized New Brunswick Cardiology Group/RWJ Physician Enterprise to submit claims to Medicare, Medigap, and commercial insurance payers on my behalf. I assign any payment and/or benefit from these payers for these services to New Brunswick Cardiology Group/RWJ Physician Enterprise. I further authorize the release of any medical records necessary for the adjudication and payment of claims or any authorizations for services or procedures rendered or to be rendered. I understand balances for deductibles, co-insurance, co-payments, and non-covered services are my financial responsibility. If any balances become delinquent and are referred for further collection activity, I may become liable for any cost of collection including collection fees, court fees, and legal fees.

_____

SIGNATURE: DATE:

New Brunswick Cardiology Group, P.A. | RWJBarnabas HEALTH

Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our Patient Information Sheets before seeing the doctor.

We will only bill insurance carriers with whom we participate (have signed an agreement with). Unless previous arrangements have been made, all payments are due at the time of the appointment. Payment may be made by cash, check, MasterCard, Visa, Discover or American Express.

Regarding Managed Care Insurance with which we participate: You are responsible to supply our staff with your primary and secondary insurance identification card(s) at the time of your appointment. If your insurance company requires a referral from your primary doctor, you must also present this to our receptionist prior to being seen, as we cannot bill your insurance without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full. If your insurance requires copay, it must be paid **at the time** of the appointment.

At times your insurance carrier will deny payment for authorized services. If so, you may be asked to help resolve these issues with your carrier.

Regarding Non-Participating Insurances: If we do not participate with your insurance, the bill is your responsibility and is due at the time of service. We accept cash, check, MasterCard, Visa, Discover and American Express. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

Our practice is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our area. We know how confusing insurance plans can be. If you have any questions, feel free to ask us. We may be able to help you.

We do participate with Medicare. This means that we will submit your claim to Medicare. The 20% difference between what Medicare "allows" and what Medicare "pays" will be sent to your secondary insurance if you have one, or to you. You will also be responsible for payment of your yearly deductible.

Returned Check Fee - $35.00. Our bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs.

If you are unable to keep a scheduled appointment, 24 hours notice of cancellation is required. Otherwise a $35.00 charge will be made for the time that was reserved to you.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. **Accounts that go to collection will be subject to a 25% charge.**

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask. If you cannot pay in full at the time of service, please let us know before you see the doctor that you would like to discuss a payment plan.

I have read the above New Brunswick Cardiology Group, PA Financial Policy. I understand and agree to abide by its terms.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Print Name of Patient/Parent/Guardian

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PATIENT MEDICAL RECORD AUTHORIZATION FORM

Patient Name:_____

Address: _____
(Include street, city, state, and zip code)

Date of Birth: _____ Tel.:_____

I hereby authorize _____ (Provider/Practice Name) to release my health information to:

New Brunswick Cardiology Group, PA
Robert Wood Johnson Physician Enterprise
75 Veronica Avenue, Suite 101
Somerset, NJ 08873
Tel: 732-247-7444
Fax: 732-247-5119

The following information to be disclosed (Please check one box for each item) on or before _____(Appointment date):

YES	NO	
___	___	Physician Notes
___	___	Lab results (w/in the last 6 months)
___	___	Cardiac studies
___	___	Complete record
___	___	Other: _____

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infections, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. If you experience discrimination because of the release of disclosure of HIV-related information, you may contact the New Jersey Civil Rights Commission at (973) 648-2700.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

I understand that this authorization is valid for one year (1 year) from this date or until _____ and may be revoked by me at anytime.

_____ Date: _____
Signature of Patient or Legal Representative

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DISCLOSURE TO DESIGNATED FAMILY/FRIENDS/CAREGIVERS

Print Patient Name: _____ **Date of Birth:** _____

When the office needs to reach you regarding an appointment with test results, we will make every effort to reach you personally. If we are unable to speak with you, we will leave a generic message for you to contact the office. HIPAA regulations prohibit our practice from leaving detailed information on an answering machine/voicemail; therefore you will be asked to call our practice back.

The office will never discuss your medical information unless we have a signed authorization on file. I understand that I am not required to list anyone.

Policy for discussing your medical information with someone who contacts our office:
I authorize Robert Wood Johnson Barnabas Health to disclose medical information as needed to the following designated individual(s) in my healthcare. I understand that this authorization will remain in effect until I make written request to rescind it.

Please indicate the person(s) with whom we may discuss your medical care by providing the name, date of birth, phone number and relationship for which we will use for identification purposes. This allows the office staff to provide **any** and **all** information requested by the person(s).

1. Print Name: _____ Date Of Birth: _____

   Phone Number: _____ Relationship: _____

2. Print Name: _____ Date Of Birth: _____

   Phone Number: _____ Relationship: _____

3. Print Name: _____ Date Of Birth: _____

   Phone Number: _____ Relationship: _____

4. Print Name: _____ Date Of Birth: _____

   Phone Number: _____ Relationship: _____

Patient Signature: _____ **Date:** _____

Office Staff Witness Signature: _____ **Date:** _____