Welcome to RWJPE-New Brunswick Cardiology Group

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

- Patient Information Form
- Health History Form
- Release of Medical Records Form

It is imperative you arrive 30 minutes prior to your appointment time so we may complete your electronic health and financial records.

Please bring with you at the time of your visit:

- Most recent EKG and other cardiac related reports
- Prescription Medications in their containers
- Letter requesting a consult if being sent to NBCG for a cardiology consult
- Health Insurance ID card(s)
- A valid picture 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 RWJPE-New Brunswick Cardiology Group. We look forward to meeting you and the opportunity to provide the highest quality cardiology care possible.

Sincerely,

The Physicians and Staff of RWJPE-New Brunswick Cardiology Group

11/18dfw
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?)

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

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

Associated signs/symptoms: ________________________________

(What other associated problems have you been having?)

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

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

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

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)

<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<td>Chickenpox</td>
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<td>Whooping cough</td>
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<td>Scarlet Fever</td>
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<td>Diphtheria</td>
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<td>Smallpox</td>
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<td>Pneumonia</td>
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<tr>
<td>Rheumatic Fever</td>
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<td>Heart Disease</td>
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<td>Arthritis</td>
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<tr>
<td>Venereal Disease</td>
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<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Anemia</td>
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<tr>
<td>Bladder Infections</td>
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<tr>
<td>Epilepsy</td>
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<tr>
<td>Migraine Headaches</td>
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<td>Tuberculosis</td>
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<td>Diabetes</td>
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<td>Cancer</td>
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<td>Polio</td>
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<td>Glaucoma</td>
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<td>Hemia</td>
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<td>Blood or Plasma</td>
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<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Low Blood Pressure</td>
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<tr>
<td>Hemorrhoids</td>
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<td>Date of last chest x-ray</td>
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<td>Asthma</td>
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<td>Hives or Eczema</td>
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<td>Polio</td>
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<thead>
<tr>
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<tbody>
<tr>
<td>Back Trouble</td>
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<tr>
<td>Ulcer</td>
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<tr>
<td>Kidney Disease</td>
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<td>Thyroid Disease</td>
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<tr>
<td>Bleeding Tendency</td>
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<tr>
<td>Any other disease</td>
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(please list):

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

Medications: (Include Nonprescription):

__________________________________________________________________________

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

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  Particles  Noise

Family medical history:

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<tr>
<th>Disease</th>
<th>Age</th>
<th>If deceased, cause of death</th>
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<tbody>
<tr>
<td>Author</td>
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<tr>
<td>Mother</td>
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<td>Siblings</td>
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<td>Spouse</td>
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<td>Children</td>
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</table>
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.
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: ________________
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
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