New Patient Questionnaire

Patient Name: _____ Patient ID:_____

Email address: _____ @ _____

Primary Care Physician *(most insurance companies require a PCP)*_____ _____
Date of Appointment

Reason for visit: _____

Please list All Allergies/ Sensitivities with reactions:

Drug	Reaction(s)

Local Pharmacy: _____ **Mail In Pharmacy:** _____

Please list All medications you are taking:

Medication	Dosage	How many times per Day

Patient Name: _____ Patient ID:_____

PAST MEDICAL HISTORY

Please list Past Medical Illnesses: _____

_____

Cardiovascular Illnesses: _____

_____

Please list past procedures/ testing:

	Type	Date(s)	Location
Surgeries/ Procedures *(non cardiac)*			
Cardiology Procedures *(Invasive)*			
Bypass Surgery			
Stent Placement			
Heart Cath			
Cardiology Procedures *(Non- Invasive)*			
Stress Testing			
Echocardiogram (Ultrasound of heart)			
Holter/ Event Monitor			
Electrophysiology Procedures			
Device Implants			
Pacemaker/Defibulator			
Peripheral Vascular Procedures			

CARDIAC RISK FACTOR SCREENING

History of Tobacco Use**:** □ **YES** □ **NO**

Family history of Heart Disease**:** □ **YES** □ **NO**

History of Hyperlipidemia (*high cholesterol*)**:** □ **YES** □ **NO**

History of Hypertension (*High blood pressure*)**:** □ **YES** □ **NO**

History of Diabetes Mellitus**:** □ **YES** □ **NO**

Prior History of Heart Disease**:** □ **YES** □ **NO**

Patient Name: _____ Patient ID:_____

SOCIAL HISTORY

Alcohol use: □ **YES** □ **NO**
- If yes, number of alcoholic drinks/day _____ ● Do you ever drink more: □ **YES** □ **NO**

Smoking/ Tobacco Use:
□ **Never smoked** □ **Stopped** (date): _____ □ **Current Smoker**: _____packs/day _____cigars/day

Caffeine Use: □ **YES** □ **NO**
- If yes, number of caffeinated drinks/day _____ ● Do you ever drink more: □ **YES** □ **NO**
- If yes, number of decaffeinated drinks/day _____ ● Do you ever drink more: □ **YES** □ **NO**

Exercise: □ **YES** □ **NO**
- If yes, how often: □ daily □ _____ times/week
- type of exercise: _____

Miscellaneous

Race: □ American Indian or AK Native □ Asian □ Black or African American
□ Hispanic □ Native Hawaiian or other Pacific Island □ White

Ethnicity: □ Hispanic or Latino □ NON-Hispanic or Latino

Preferred Language: □ Arabic □ Chinese □ English □ French □ German □ Hebrew □ Italian
□ Japanese □ Korean □ Portuguese □ Russian □ Spanish □ Swahili

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Please feel free to include any other information which may be pertinent to your care: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Cardiovascular Consultants of Southern Delaware

Announcing our Patient Portal!

The portal will allow you to:

- Request appointments
- Request medication refills
- Update insurance information
- Receive messages from the practice
- Send messages to the practice
- Pay balance on your account

Please visit www.cvcde.com to sign up today!

(*Please allow 24 hours after sign up for your account to be reviewed and activated. Please call 302-645-1233, if you have questions*)

Patient Name:_____ Patient ID:_____ Date: _____

Cardiovascular Consultants of Southern Delaware
HIPAA Questionnaire

1. Please list the name and phone number of a family member or other person, *if any*, who we may inform

   About your general medical condition and diagnosis: □ **NONE** or please PRINT other: _____

   _____

2. Please list the name and phone number of a family member or other person, *if any*, who may be authorized to discuss your billing statement: □ **NONE** □ **SAME AS ABOVE** or please PRINT other:

   _____

3. Please list the name and phone number of a family member or other person, if any, who we may contact in

   An emergency: □ **NONE** □ **SAME AS ABOVE** or please PRINT other: _____

   _____

4. Please PRINT the address where you would like your billing statement sent:

   □ **SAME AS MY REGISTRATION ADDRESS** or please PRINT other: _____

   _____

5. Please PRINT the address of where you would like the other correspondence from our office sent:

   □ **SAME AS MY REGISTRATION ADDRESS** or please PRINT other: _____

   _____

6. Other than your home phone number, please print the telephone number, if any, where you want to receive

   calls about your appointments, lab results, x-rays, or other health care information: _____

   _____

7. Can confidential messages be left on your home answering machine or voicemail: □ **YES** □ **NO**

8. Can confidential messages be left at your place of employment: □ **YES** □ **NO**

_____ _____
Patient/ Legal Guardian Signature date

********** All correspondence that is mailed will be marked "Personal and confidential" **********

Barry S. Denenberg, MD, FACC
R. Alberto Rosa, MD, FACC
Kenneth P. Sunnergren, MD, FACC
G. Robert Myers, MD, FACC
Firas El Sabbagh, MD, FHRS

Cardiovascular Consultants of Southern Delaware

Patient ID:_____

Date: _____

Medical Records Release

To: _____

I hereby authorize you to use or disclose the specific information described below, only for the Purpose and parties also described below:

□ Medical Records only

□ Include mental health records

□ Include drug and alcohol records

□ Include STD records

□ Include HIV records

□ Include genetic information records

Entity requesting the information and authorized to make the requested use:

Cardiovascular Consultants of Southern Delaware

□ Lewes, 16704 Kings Highway, Lewes, DE 19958, (302) 645 1233(p); (302) 645 1228(f) ***or*** (302) 644 3826(f)

□ Millville, 35141 Atlantic Avenue, Unit 3, Millville, DE 19970, (302) 541 8138(p); (302) 541 8425(f)

This information is being requested for the following purpose(s):

□ Medical Treatment □ Legal Proceeding □ Insurance Purposes □ Other: _____

This authorization shall remain in effect from the date signed below until: _____
(*Expiration date/event*)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, Attention: Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer is protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research/ related treatment, in which case you may refuse to provide that research-related treatment)
- I acknowledge that I have received the "Notice of Privacy Practice" and authorize **CVCSD** to Release or obtain my private information for the purposes of my treatment, to obtain payment from a third party or conduct normal healthcare operations, per the Health Insurance Portability and Accountability Act of 1996.

□ **I DECLINE TO SIGN THIS RELEASE.** _____
(Signature)

PRINTED Patient Name: _____

Signature: _____

Last four digits of Social Security: _____ Date of Birth: _____

If signed by personal representative, please include printed name and relationship: _____

Lewes Office:
16704 Kings Highway
Lewes, De 19958-4929
(302) 645 1233 phone
(302) 645 1228 fax

Millville Office:
35141 Atlantic Avenue
Unit 3
Millville, De 19970-6954
(302)541 8138 phone
(302) 645 1228 fax
www.cvcde.com

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Firas El Sabbagh, MD, FHRS

Cardiovascular Consultants of Southern Delaware

Patient ID: _____

Date: _____

Financial Policy Effective Jan 1, 2017

Please initial each statement below to acknowledge your understanding in its entirety

Appointment Cancellation:

_____ Our policy is to charge for any missed appointments that are **not cancelled 24 hours prior** to your appointment. There will be a $25 charge for a missed appointment. These charges will be ***your responsibility*** and billed directly to you. **Insurance will *not* cover** charges for missed appointments.

_____ If you are scheduled for Nuclear Stress Testing and do not cancel/reschedule your appointment within the **required 24 hour advanced notice *you* will be responsible for the $100 fee** associated. This fee is a result of supplies being ordered specifically for your testing that cannot be used/disposed of in the event the order is not canceled.

Referrals:

_____ If you have insurance that requires a referral, you must have your referral prior to receiving treatment. It is your responsibility to obtain all necessary referrals from your primary care physician. Patients without proper referrals who elect to receive service from our providers will be required to make payment in full at the time of service.

Self Pay/Non Covered Services:

_____ We participate in most insurance plans, however it is your responsibility to confirm with your insurance if services rendered will be covered. Our practice, as a courtesy verifies your insurance on file with the insurance agencies but this is not a guarantee of payment.
_____ Patients who are uninsured or have non covered services are expected to pay at the time of service. We offer a 40% discount for paying for your services at the time they are rendered.

Collections:

_____ If your account becomes delinquent you agree to pay any charges to collect your balance due, including court costs, and/or collection agency fees. After being billed 4 statements you will receive a letter stating you have 10 days to pay in full. Payment plans are available but are not to exceed a 12 month time frame, unless otherwise negotiated. You must contact billing to negotiate your payment plan or risk collection. ***Please be aware that if your account becomes delinquent or in a collection status you will be expected to resolve your debt as negotiated with the billing department prior to being able to schedule or keep previously scheduled appointments.***

We must obtain a copy of your identification, current insurance card, and social security number in order to file your claim. Copays and outstanding debt are due at check in. Co-insurance and deductibles will be billed after insurance has processed your claim.

PRINTED Patient Name: _____

Signature: _____

Last four digits of Social Security: _____ Date of Birth: _____

If signed by personal representative, please include printed name and relationship below:

_____

Lewes Office:
16704 Kings Highway
Lewes, De 19958-4929
(302) 645 1233 phone
(302) 645 1228 fax

Millville Office:
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Millville, De 19970-6954
(302)541 8138 phone
(302) 645 1228 fax

www.cvcde.com

CARDIOVASCULAR CONSULTANTS OF SOUTHERN DELAWARE, LLC

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16704 Kings Highway, Lewes, DE 19958
(302) 645 1233 phone/ (302) 645 1228 fax

35141 Atlantic Avenue #3, Millville, DE 19967
(302) 514 8138 phone/ (302) 541 8425 fax

Patient ID:_____

Medicare/ Medigap Authorization and Assignment

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Cardiovascular Consultants** for any services furnished me by **Cardiovascular Consultants**. Regulations pertaining to Medicare assignment of benefits apply.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Should this claim not be paid in full by myself or by the insurance company (according to Medicare participatory rule) then I will be responsible for any reasonable collection expenses and attorney fees required to secure full payment.

_____ _____ _____
Signature of Subscriber or Beneficiary Identification Number Date

_____ _____
Printed Name of Subscriber or Beneficiary Date of Birth

Medigap Authorization Statement

I authorize any holder of medical information about me to release to **Cardiovascular Consultants** any information needed for this or a related Medigap claim, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

SIGNATURE_____ DATE_____

Policy Number:_____