Essex Cardiology Group, P.C.

Lawrence Fabrizio, D.O. FACC **Stephen M. Levy, M.D. FACC**
Sargis A. Khoobiar, M.D. FACC **Jeffrey Lander, M.D. FACC**

Date:	Patient Last Name, First, Name, & Middle Initial:	Date of Birth:	Age:	Social Security Number:
Address:	City:	State:	Zip:	
Home Phone Number:	Cell Phone Number:	Work Phone Number:	Email:	
Employment Name:	Address, City, State, Zip Code:	Occupation		
Patient is: ☐ Single ☐ Married ☐ Widowed	Patient Sex: ☐ Male ☐ Female			

POLICY HOLDER INFORMATION:

Insured Last Name, First Name, & Middle Initial	Insured Date of Birth:	Relation to Patient:

INSURANCE INFORMATION:

Name of Primary Insurance Carrier:	Member ID Number:	Group Number:
Name of Secondary Insurance Carrier:	Member ID Number:	Group Number:
Insured Name on Secondary Insurance:	Date of Birth (Required):	
Reason for this visit:	Date Symptoms began:	
Emergency Contact Name:	Phone Number:	Relationship:
Pharmacy Name:	Address, City, State, Zip Code:	Phone Number:
Name of Referring Physician:	If not referred by a physician, how did you hear of us?	Primary Physician:

I acknowledge receipt and understand the HIPAA privacy laws as they pertain to Practice Associates Medical Group, Morristown Medical Center, Overlook Medical Center, and Affiliates.
Patient/Guardian Signature: _____

I authorize Practice Associates Medical Group Practice Associates Medical Group, Morristown Medical Center, Overlook Medical Center, and Affiliate's staff to leave messages at my home, via writing and voice regarding my medical care.
Patient/Guardian Signature: _____

I authorize the following person to receive information regarding my medical care.
Name: _____ Relationship: _____
Patient/Guardian Signature: _____

PLEASE READ THE FOLLOWING FINANCIAL AGREEMENT & SIGN WHERE INDICATED

- I authorize the release of information necessary to any entities to secure the payment of benefits submitted for services rendered by Essex Cardiology Group, P.C., on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service, Advanced Electronic Medical Billing, Inc., to secure the payment of benefits. I further agree & acknowledge that my signature on this document authorizes claims to be submitted for benefits for services rendered without obtaining my signature on every claim form. I assign directly to Essex Cardiology Group, P.C insurance payments for all services rendered. I also authorize Essex Cardiology Group, P.C & Advanced Electronic Medical Billing, Inc., to file a complaint on my behalf for any dispute & or appeal regarding fair and accurate reimbursement.

- I understand I am financially & fully responsible for all charges incurred if my insurance carrier denies payment for any reason. I understand I will be financially responsible for any deductibles, coinsurance or co-pays according to my individual benefit plan. I understand I will be invoiced for the amount shown as patient responsibility as indicated by my insurance carrier. Payment is due upon receipt of the invoice. I understand if I do not agree with the amount owed, I must dispute this directly with my insurance carrier, since the amount owed is based on my individual plan. I understand all co-payments must be paid at the time service is provided. I understand that a delinquent balance must be paid in full prior to any future appointments.

- I understand I am fully responsible for contacting my insurance company prior to scheduling an appointment or receiving services, to determine if the provider participates with my specific plan, determine if a referral or pre-authorization is needed, & understand any coverage limits. I understand that some insurance carriers may offer several contracts for physician participation, & I must check with my insurance carrier to verify participation for my individual plan. If no payment is issued by my insurance carrier due to a lack of referral or prior authorization as required by my plan, I understand I am fully responsible for all charges and payment is due upon receipt of invoice.

- In the event my insurance carrier pays me directly, I agree to reimburse Essex Cardiology Group, P.C the same amount in addition to any copay, coinsurance or deductible due. I agree to send in payment within 10 days of receipt. I agree to provide Essex Cardiology Group, P.C with current insurance information and advise of any change within 30 days from service date. I understand if I do not provide correct insurance information, I am fully responsible for all charges.

- I understand that payment is due upon receipt of invoice. I will be responsible for any returned check fees. I understand that if my account is referred to collections, I will be responsible for all collection costs involved, in addition to my balance due. Any credits due will remain on file and applied to future balances owed, unless a refund is requested. I understand I will owe $50.00 if an appointment is missed/cancelled without 24 hours prior notice; I understand I will owe $150.00 for missed/cancelled **testing** appointments without 24 hours prior notice.

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SIGNATURE REQUIRED BELOW

Patient or Guarantor Signature Required (Must be 18 Years of Age) Date:

Please print name & DayTime Telephone Number
Please print full mailing address:

Essex Cardiology Group, P.C.

Name: _____ DOB: _____ Date: _____

REVIEW OF SYSTEMS

PLEASE INDICATE IF YOU HAVE EXPERIENCED THE FOLLOWING SYMPTOMS

Cardiovascular
☐ Chest Pain/Pressure/Heaviness/Tightness ☐ Palpitations ☐ Murmur ☐ Dizziness
☐ Fainting spells ☐ Awake at night w/difficulty breathing
☐ Require multiple pillows or upright position to sleep ☐ Ankle/Leg Swelling
Comments _____

Vascular
☐ Transient Blindness ☐ Non-healing foot ulcer
☐ Pain/Cramping/Discomfort in buttocks, thigh, calf when walking
Comments _____

General
☐ Weight Change ☐ Weakness ☐ Sweating ☐ Fatigue ☐ Nightsweats ☐ Fever or Chills
Comments _____

Skin
☐ Hair or Nail Changes ☐ Itching ☐ Rash ☐ Dryness Comments _____

Eyes
☐ Wear glasses/contacts ☐ Vision Changes ☐ Pain ☐ Blurry Vision
Comments _____

Ear, Nose, Throat
☐ Headaches ☐ Difficulty Hearing ☐ Nasal Discharge ☐ Nosebleeds ☐ Dentures
☐ Hoarseness ☐ Sore Throat ☐ Migraine Headaches Comments _____

Pulmonary
☐ Wheezing ☐ Shortness of Breath ☐ Coughing Blood ☐ Cough ☐ Sputum ☐ Snoring
☐ Difficulty Breathing Comments _____

Gastrointestinal
☐ Appetite Change ☐ Difficulty Swallowing ☐ Nausea ☐ Constipation ☐ Abdominal Pain
☐ Diarrhea ☐ Vomiting ☐ Indigestion ☐ Hemorrhoids ☐ Heartburn
☐ Black, Tarry Stools ☐ Blood in Stool
Comments _____

Genitourinary
☐ Frequent Urination ☐ Blood in Urine ☐ Pain with Urination ☐ Incontinence
☐ Urgency ☐ Difficulty Urinating ☐ Abnormal Vaginal Bleeding ☐ Erectile Dysfunction
Comments _____

Endocrine
☐ Heat Intolerance ☐ Cold Intolerance ☐ Hair Loss ☐ Tremor ☐ Hormone Therapy
Comments _____

Allergic History
☐ Asthma ☐ Hay Fever ☐ Food Allergies ☐ Latex Allergy Comments _____

Musculoskeletal
☐ Trauma ☐ Swelling in Joints ☐ Arthritis ☐ Gout Comments _____

Blood-lymph
☐ Anemia ☐ Bleeding Tendencies ☐ Easy Bruising ☐ Prior Transfusions
☐ Lymph Node Enlargement Comments _____

Neurologic
☐ Seizures ☐ Tingling ☐ Loss of Sensation ☐ Speech Difficulty ☐ Memory Disturbance
☐ Coordination Problems ☐ Weakness of arm/leg Comments _____

Psychologic
☐ Mood Changes ☐ Sleep Disturbance ☐ Drug, Alcohol Abuse ☐ Anxiety-Panic
☐ Depression Comments _____

ESSEX CARDIOLOGY GROUP, P.C.

"Preventive and Comprehensive Cardiac Care"

*Diplomates in The American Board of Internal Medicine
†Diplomates in The American Board of Cardiovascular Disease

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REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE/FAX#: _____

I HEREBY REQUEST AND AUTHORIZE YOU TO RELEASE MEDICAL RECORDS TO:

ESSEX CARDIOLOGY GROUP, P.C.
10 JAMES STREET, S-130
FLORHAM PARK, NJ 07932
973-736-9557
FAX: 973-736-9757

PATIENT NAME/DOB: _____

ADDRESS: _____

DATES OF TREATMENT: _____

PATIENT SIGNATURE: _____

DATE: _____

ECG INITIALS _____
Date Records Received _____

ICANL Nuclear Cardiology
Accredited Nuclear Cardiology Laboratory

ICAEL
Accredited Echocardiography Laboratory

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Date: _____

Patient Name: _____

Date of Birth: _____

I authorize the following person to receive information regarding my medical care.

Name: _____

Relationship: _____

Patient/Guardian Signature:

_____

ICAEL
Nuclear Cardiology
Accredited Nuclear Cardiology Laboratory

ICAEL
Accredited Echocardiography Laboratory

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