**ALAN KALISCHER, M.D. F.A.C.C.**

 **INSURANCE INFORMATION AND AUTHORIZATION**

 **PATIENT INFORMATION**

PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SOC.SEC\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE: \_\_\_\_\_\_\_ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE: \_\_\_\_\_SEX: MALE/FEMALE RACE: \_\_\_\_\_\_\_\_\_\_\_\_MARITAL STATUS: MARRIED/SINGLE/WIDOWED/DIVORCED

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMERGENCY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **WORK INFORMATION:**

EMPLOYER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER’S NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DOCTOR INFORMATION:**

PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHYSICIAN NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE: \_\_\_\_\_ZIP: \_\_\_\_\_\_\_\_\_\_

 **RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING:**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PRIMARY INSURANCE:**

INSURANCE COMPANY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SECONDARY INSURANCE:**

INSURANCE COMPANY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT, RELEASE, AND AUTHORIZATION:**

I UNDERSTAND, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR. KALISCHER, MD, FOR ANY SERVICES FURNISHED BY HIM. I AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY OR ITS AGENTS ALL INFORMATION NEEDED TO REEVALUATE AND ADMINISTER CLAIMS. I AUTHORIZE THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO DR. KALISCHER, MD, FOR SERVICES FURNISHED BY HIM.

I AUTHORIZE DR. KALISCHER TO RELEASE ANY INFORMATION NEEDED TO EVALUATE CLAIMS TO THE HEALTHCARE FINANCING ADMIN.

I AUTHORIZE DR. KALISCHER TO PREFORM ANY OFFICE PROCEDURES HE DEEMS NECESSARY TO EVALUATE/TREAT MY CONDITION.

I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THE PRIVACY POLICY OF THIS OFFICE

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN**

**Fanwood-Westfield Cardiology, L.L.C**

 **NEW PATIENT HISTORY FORM**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRING PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHARMACY NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_

**DRUG ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ARE YOU ALLERGIC TO CONTRAST DYE? YES/NO**

**MEDICAL HISTORY PREVIOUS HOSPITALIZATIONS/SURGERIES: WHEN?**

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DIABETES YES/NO

HYPERTENSION YES/NO

CANCER YES/NO

STROKE/TIA YES/NO

HEART DISEASE YES/NO

BLEEDING TENDENCY YES/NO

STOMACH PROBLEMS YES/NO

MAJOR INFECTIONS YES/NO

HEREDITARY DEFECT YES/NO

LUNG PROBLEMS YES/NO **CURRENT MEDICATIONS:**

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KIDNEY PROBLEMS YES/NO

LIVER PROBLEMS YES/NO

**IF YES EXPLAIN:**

**SOCIAL HISTORY:**

**MARITAL STATUS:** SINGLE/MARRIED/SEPARATED/DIVORCED/WIDOWED

**ALCOHOL USE:** YES/NO **HOW MUCH?** \_\_\_\_\_\_\_ DAY/MONTH/YEAR

**TOBACCO USE:** YES/NEVER/PREVIOUSLY **HOW MUCH?** \_\_\_\_\_\_\_ DAY/WEEK

**SUBSTANCE ABUSE:** YES/NEVER/PREVIOUSLY **HOW MUCH?\_\_\_\_\_\_\_\_** DAY/WEEK **TYPE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXPOSURE TO CHEMICALS**? YES/NO **TYPE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT TYPE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EATING HABITS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SEXUAL ACTIVE:** YES/NO

**EXERCISE:**YES/NO **HOW MUCH**\_\_\_\_\_\_\_\_WEEK

**FAMILY HISTORY:**

 **AGE: DISEASES:**

MOTHER: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIBLINGS: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDREN: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Financial Agreement**

Dr. Alan Kalischer’s goal is to provide and maintain a good physician-patient relationship. Informing you in advance of our Office Policy allows for a good flow of communication, and enables us to achieve this goal. Please read this document carefully and if you have questions please do not hesitate to ask a member of our staff.

* According to your insurance plan, you are responsible for any and all

co-payments, deductibles and co-insurances. Co-pays and Deductibles are due at the time of service.

* If your last appointment exceeds a ONE YEAR (12 MONTHS) period,

Dr. Alan Kalischer will not refill any prescriptions until you are seen for an exam in our office.

* Patient balances are billed monthly after the payment has been received from your insurance company.
* If previous arrangements have not been made with our office, any account balances exceeding 90 days, will be submitted to a collection agency.
* Patients with a total of (2) consecutive NO SHOWS in a calendar year will be charged a fee of $100 - Exceptions will be considered upon circumstances.

I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as stated above.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payments from my insurance company to Dr. Alan Kalischer for services rendered to me in the office, and or hospital.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEGEMENT OF PRIVACY POLICY**

 **HIPAA**

The undersigned (patient or legal representative) consents to the use or disclosure of my (patient)

individually identifiable health information by Fanwood Westfield Cardiology and its physicians and

staff, as outlined by Federal Law for the purposes set forth below.

* To provide the patient with medical treatment and related services, including coordination or management of the patients care with a third party that is also involved in the patient’s treatment, such as your Primary Care physician, a Specialist, or a Laboratory to which we refer the patient for further care or tests.
* As necessary to run our business operations and to support the core functions of treatment and payment, including without limitations, quality assessment and improvement activities, employee evaluation, activities, conducting medical reviews, legal auditing services, business planning and development activities, business management and general administrative activities.
* As required or permitted by applicable state and/or federal law as described at greater length in Notice of Privacy Practices provided to you along with this Acknowledgement Of Privacy Policy.

Furthermore, in order to facilitate and expedite my care, my signature below authorizes

 Dr. Alan Kalischer to have access to and obtain copies of my prior, current and future medical records

(physician, hospital, laboratory etc.) for the purpose of treatment and payment in accordance with the

HIPPA regulation.

In addition, my signature below confirms that I have received the complete

“Notice of Privacy Practices”. This authorization will remain valid until my written revocation.

Patient authorizes the release of her health information to the following family member(s), close

personal friend(s), or other person(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient (or Patient’s Representative) Date

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Signature of Patient (or Patient’s Representative) Relationship to Patient)