Registration Form (New Patients)

Ronald J. Bloom, MD, FACC
Brett Nowlan, MD, FACC, RPVI, ABCL
Patrick J. Corcoran, MD, FACC, FSCAI, RPVI
Carolyn M. Kosack, MD, FACC
Tracy Patel, MD, FACC, RPVI
Maria Theresa Santos, MD, FACC, RPVI

Cottage Grove Cardiology, P.C.

Specializing in Cardiovascular Medicine

Julian Esteban, MD,MS, FACC
Jawad Haider, MD, FACC
Vincent F. Romano, MD, FACC
Erin Vincent, PA-C
Gabriella Smith, PA-C
Jason Cornelio, PA-C

Account #

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to complete our registration form. If you have any questions, we will be glad to help you. All of us at Cottage Grove Cardiology, P.C. look forward to working with you in maintaining your cardiac health.

Section 1: Patient Information

Last Name: _____ First Name: _____ Middle Initial _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Gender: Male or Female

Social Security Number: _____

Date of Birth: _____

Employer: _____

Street Address: _____

City: _____ Zip Code: _____

Phone: _____

Marital Status: Single Married Divorced Widowed

Spouse Name: _____

It is permissible to contact me at the phone numbers listed below:

□ Home: _____

□ Work: _____

□ Cell: _____

It is permissible to leave detailed voice messages at the locations checked below:

□ Home □ Work □ Cell

It is permissible to leave a message with other people who answer the phone numbers checked below:

□ Home □ Work □ Cell

It is permissible to contact me by email: □ Yes or □ No

Email Address: _____

I understand that personal information such as correspondence, billing and medical records sent by email per my request is not encrypted and CGC is not responsible if my information is obtained by a third party.

Patient Initials: _____

Primary Care Physician: _____

Street Address: _____

City: _____ Zip Code: _____

Referring Physician: _____ Phone Number: _____

Pharmacy Name & Location: _____

Section 2: Emergency Contact

Name: _____ Phone Number: _____

Relationship to Patient: _____

PLEASE SEE REVERSE SIDE

Section 3: Insurance and Billing Information

Primary Insurance: _____ Secondary Insurance: _____

Subscriber: _____ Subscriber: _____

ID#: _____ ID#: _____

Group #: _____ Group #: _____

Authorization, Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage as indicated on this form and/or according to the identification cards I presented. I, by my signature below, assign directly to Cottage Grove Cardiology, P.C. and/or its individual providers or duly appointed agents, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance according to my current policy details and the contract that may exist between my insurance company and this practice. I authorize the release of medical other information necessary to process this claim. I also request payment of governmental benefits either to myself or to the party who accepts assignment. I authorize the use of my information and (signature on file) all insurance submissions. I have read and agree to comply with the Financial Agreement practices of Cottage Grove Cardiology, P.C.

Section 4: HIPAA Communication

It is the policy of this office not to release confidential medical information regarding your treatment to family members or friends except to a **parent/legal guardian**, other persons authorized by the patient or as we may reasonably infer from circumstances. For example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person in entitled to receive information regarding your treatment, in emergency situations, or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below. **By signing below, you authorize the following people to receive information regarding your treatment or care**. At any time you would like to make changes by adding or removing a name please do so in writing.

NAME OF PERSON: _____ PHONE: _____

RELATIONSHIP TO YOU: _____

NAME OF PERSON: _____ PHONE: _____

RELATIONSHIP TO YOU: _____

_____ _____ _____

PATIENT OR REPRESENTATIVE SIGNATURE NAME PRINTED DATE

**Please provide a copy of your appointment as legal guardian, power of attorney, conservatorship or other court appointment if you are signing on behalf of a patient who is unable to exercise self-determination.

Patient is unable to sign because: _____ Staff Initials_____

FINANCIAL POLICY &
ACKNOWLEDGEMENT OF NPP

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Office Policy

Our goal is to develop a good patient-physician relationship. Our Office Policy will help you to know what to expect during and after your visit with us. Please let us know if you have ANY questions.

Appointments

1) If you are not able to keep an appointment, we would appreciate a call no later than 10 am on the day **before** your appointment. **No-Show Charge:** There is a charge of $50 for missed doctor's visits and $100 for a missed testing appointment (echo vascular, stress).
2) If you are more than 15 minutes late for your appointment, we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time. However, we spend as much time as is necessary with each patient. We appreciate your understanding.

Insurance Plans

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) It is your responsibility to understand your benefit plan such as covered services, participating laboratories, referrals or authorizations required prior to a procedure.

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service.
3) Self-pay patients or patients with insurance with which we do not participate are expected to pay for services in FULL at the time of the visit or make payment arrangements with the billing office.
4) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
5) We accept cash, checks, Visa, and MasterCard. You can also pay online at www.cottagegrovecardiology.com
6) A $20 fee will be charged for any checks returned for insufficient funds.

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your most recent test and the note from the last visit to your physician, free of charge. We need 48 hours' notice.
2) A copy of your complete record is available for a $.65-per-page fee

Prescription Refills

1) For monthly medication refills, we require 2 business days to refill the order. Please plan accordingly.

I have read, understand, and agree to comply with these policies.

Patient Name_____ **Date** _____

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at 860-761-9460, or in writing to us at:

Mark Salsbury
Cottage Grove Cardiology, PC
711 Cottage Grove Road
Bloomfield, CT 06002

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of this **Notice of Privacy Practices** is available in the reception area and that I may request a copy be provided to me at any time.

_____

Print Name

_____ _____ _____

Patient (or Patient Representative*) Signature Relationship to Patient Date

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For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) Employee Initials: _____

Employee Name: _____ **Date:** _____

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.