NEW YORK CARDIOLOGY ASSOCIATES P.C.

425 E. 61st Street, 6th Floor, New York, NY 10065
Phone: 212-752-2000 | Fax: 212-752-5822

HOLLY S. ANDERSEN, M.D.
FREDERICK J. FEUERBACH, M.D.
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NISHA JHALANI, M.D.
LAWRENCE A. KATZ, M.D.
MARTIN R. POST, M.D.
GERARDO L. ZULLO, M.D.

NEW PATIENT MEDICAL HISTORY

PATIENT INFORMATION

Name _____ (Last) _____ (First) _____ (Middle Initial) Date of Birth _____ (MM/DD/YYYY) Gender _____

Primary Phone _____ (❑ Home / ❑ Work / ❑ Cell) Email _____ Secondary Phone _____ (❑ Home / ❑ Work / ❑ Cell)

Marital Status _____ Occupation _____

DOCTOR / EMERGENCY CONTACT

Referring Doctor _____ Phone Number _____

Primary Care Doctor (if different) _____ Phone Number _____

Emergency Contact _____ Relationship: _____ Cell Phone _____

MEDICAL HISTORY

Have you ever experienced or been diagnosed with any of the following conditions?

❑ High blood pressure	❑ Stroke	❑ Diabetes	❑ Kidney disease
❑ Heart murmur	❑ High cholesterol	❑ Sleep apnea	❑ Liver disease
❑ Angina	❑ Fainting/Dizziness	❑ Autoimmune disease	❑ Thyroid disease
❑ Heart attack	❑ Vascular disease	❑ Lung disease	❑ Cancer Type
❑ Irregular heart rhythm	❑ Aortic aneurysm	❑ Stomach/intestinal problems	❑ Other _____

Details on conditions selected above, if needed _____

Surgical History: please list the name and date of any surgeries you have had _____

Hospitalizations: please list the date, location, and reason for any prior hospitalizations _____

Check any vaccinations you have received, including dates if known.

❑Influenza _____ ❑ Shingles _____ ❑ Pneumonia _____ ❑ Hepatitis A _____ ❑ Gardasil _____

❑COVID-19 _____ ❑ RSV _____ ❑ TDAP (tetanus) _____ ❑ Hepatitis B _____ ❑ Other _____

Do you have known allergies (e.g. medications, foods, latex…)? Yes ❑ | No ❑ - If yes, list the allergies and what reaction you have had to each.

Do you take any over the counter vitamins or supplements? Yes ❑ | No ❑ - If yes, write them below.

List all medications you are currently taking.

Medication	Dose	# times/day	Medication	Dose	# times/day

Which of the following screening exams have you had?

	Date	Doctor/Location
❑ Colonoscopy		
❑ Skin exam		
❑ Eye exam		

WOMEN ONLY	Date	Doctor/Location
❑ GYN exam		
❑ Mammogram		
❑ Bone density scan		

PERSONAL HISTORY

Yes ❑| No ❑ Do you currently smoke? ❑Cigarettes ❑Pipe ❑Cigars ❑Vaping #daily_____ #years___

Yes ❑| No ❑ Have you ever smoked? ❑Cigarettes ❑Pipe ❑Cigars ❑Vaping #daily___ #years___ Date stopped _____

Yes ❑| No ❑ Do you drink alcohol? If yes, # days per week __, # glasses/week of wine __ /beer__ /liquor __

Yes ❑| No ❑ Do you use any recreational drugs or substances? If yes, please specify: _____

Yes ❑| No ❑ Do you drink coffee? # cups daily _____

Yes ❑| No ❑ Do you follow a specific diet? Please specify _____

Yes ❑| No ❑ Do you exercise regularly? Type and frequency _____

How would you rate your overall level of physical activity? ❑Low ❑Moderate ❑High

How would you rate your overall level of stress? ❑Low ❑Moderate ❑High

How many hours of sleep do you get per night on average? _____

WOMEN ONLY

Pregnancies _____ # Children _____

Were you diagnosed with any of these conditions during any of your pregnancies?

❑ Gestational hypertension ❑ Pre-eclampsia/eclampsia ❑ Gestational diabetes ❑ Preterm labor

Any other complications of pregnancy?

FAMILY HISTORY

Provide information for **biological relatives only**. If deceased, please list their cause of death, if known.

Father: □ Alive, age ____ □ Deceased, age ____ Medical Problems: _____

Mother: □ Alive, age ____ □ Deceased, age ____ Medical Problems: _____

Siblings: (*please circle to indicate brother or sister*)

Brother / Sister: □ Alive, age ____ □ Deceased, age ____ Medical Problems: _____

Brother / Sister: □ Alive, age ____ □ Deceased, age ____ Medical Problems: _____

Brother / Sister: □ Alive, age ____ □ Deceased, age ____ Medical Problems: _____

Brother / Sister: □ Alive, age ____ □ Deceased, age ____ Medical Problems: _____

Do you have any children? □ No □ Yes, # sons ___ # daughters ___

CHIEF COMPLAINT

What symptoms or concerns bring you to the doctor today? Please describe briefly

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PATIENT CONSENT FORM

1. I acknowledge that I may request a copy of New York Cardiology Associates' (NYCA) HIPAA Privacy Notice, which describes their obligation to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how NYCA may use and disclose my health information for treatment, payment, and health care operations. I know that I have the right to review NYCA's HIPAA Privacy Notice and to ask questions about it. I understand that NYCA is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

2. I further acknowledge that NYCA can change its HIPAA Privacy Notice in the future and that I can receive a copy of NYCA's current HIPAA Privacy Notice at any time by contacting the Privacy Officer.

3. I understand that I have the right to request that NYCA restrict its uses and disclosures of my health information for treatment, payment, or health care operations. If accepted, these restrictions will be binding on NYCA. However, I understand that NYCA is not required to agree to my requested restrictions.

4. I understand that I have the right to revoke this consent at any time in writing. However, it will not affect any actions NYCA has already taken in compliance with this consent.

5. I know that I have the right to refuse to sign this consent. However, should I refuse, NYCA may refuse to provide me with non-emergency care.

I fully understand and ☐ accept ☐ decline the terms of this consent.

PRINTED NAME OF PATIENT _____ SIGNATURE OF PATIENT OR REPRESENTATIVE _____ DATE _____

PRINTED NAME IF SIGNED ON BEHALF OF PATIENT _____ RELATIONSHIP TO PATIENT _____

INITIAL _____ **I do not request any restrictions on NYCA's uses or disclosures of my health information for treatment, payment, or health care operations.**

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FINANCIAL POLICY

Welcome to New York Cardiology Associates, P.C .! The following is a statement of our financial policy. We hope this gives you a better understanding of our billing practices. Patients cared for by our practice come with different insurance and payment options. Please understand that all the physicians in this practice do not accept the same insurances. It is important that you check with your insurance to verify your benefits, as well as the requirements of your insurance for pre-certifications for diagnostic tests, laboratory and/or pharmacy designations and referrals.

PLEASE REMEMBER TO CHECK OUT AT THE FRONT DESK AFTER YOUR VISIT

Medicare

Our physicians have opted out of the Medicare Program, including Medicare Advantage plans. You will be responsible for payment of all charges at the time of the visit. Due to federal regulations, claims will not be filed to Medicare (or Medicare Advantage plans) and you will receive no reimbursement from Medicare for our services. Supplemental Medicare insurances will also not reimburse you. Additionally, you are required to sign a Medicare Private Contract acknowledging your understanding of this policy.

Managed Care Plans

Some of our physicians are currently participating in a small number of managed care plans. You will be notified if you will be seeing a physician who does not participate with your plan. If you are seeing a physician who participates in plan, your insurance will be accepted as payment in full for covered services and you will be responsible for co-pays, co-insurances and deductibles as dictated by terms of your insurance policy. You are also responsible to notify the practice if your insurance requires a managed care referral, specific pharmacy and/or laboratory designation or pre-certification for procedures. We will verify referrals and pre-certify procedures when you choose an in-network physician.

Out-of-Network Insurances

If your doctor does not have a contractual agreement with your insurance, you will be responsible for payment of all charges at the time of the visit. We will submit a claim on your behalf to your insurance company, and you will be reimbursed by your insurance company based on your out-of-network benefits, if applicable. Some insurances and plans do not permit you to receive reimbursement for services rendered by our out of network physicians.

I understand that Dr._____ does not participate in my insurance _____ and that I am responsible for all charges.

PAYMENT FOR ALL SERVICES RELATED TO YOUR VISIT IS DUE AT TIME OF SERVICE

The following methods of payment are accepted for your convenience:

- **Cash**
- **Check**
- **All major Credit cards (Visa, Mastercard, Amex, Discover)**

I attest that I have read the above financial policy and I fully understand and agree to its terms.

PATIENT NAME _____ **INSURANCE** _____

SIGNATURE _____ **DATE** _____ **WITNESS** _____

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PREFERRED / IN-NETWORK PHARMACY AND LABORATORY INFORMATION

Patient name: _____ Date of birth: _____

PHARMACY

Our office offers Electronic Prescribing. We request that you list the pharmacy of your choice below. If you use a chain pharmacy, such as Duane Reade or CVS, please include the store number as well as the address and/or phone number. If you use a mail order pharmacy, please indicate which one below.

PHARMACY NAME: _____ STORE#: _____

ADDRESS: _____ PHONE# _____

MAIL ORDER PHARMACY (Please check only one.)

- ☐ EXPRESS SCRIPTS
- ☐ RIGHTSOURCE Rx
- ☐ CVS/CAREMARK MAIL ORDER
- ☐ COSTCO MAIL ORDER
- ☐ PRESCRIPTION SOLUTIONS
- ☐ CVS/CAREMARK SPECIALTY
- ☐ CIGNA HOME DELIVERY
- ☐ AETNA Rx HOME DELIVERY
- ☐ OTHER: _____

LABORATORY SERVICES (Please check only one.)

Lab specimen collected in our office will be sent to Quest Diagnostics. However, certain insurance carriers only cover laboratory services at 100% through a preferred laboratory. If your insurance requires you to utilize a specific laboratory, please indicate below. We strongly urge you to call your insurance carrier before coming in for services to find out which laboratory companies are in-network for your plan.

- ☐ LABCORP
- ☐ OTHER: _____

ELECTRONIC HEALTH RECORD

As a component of Electronic Health Record, the government has determined that the following demographics should be included in your patient profile.

Preferred Language

- ☐ ENGLISH
- ☐ GERMAN
- ☐ FRENCH
- ☐ SPANISH
- ☐ ITALIAN
- ☐ ARABIC
- ☐ CHINESE
- ☐ OTHER: _____

Race

- ☐ DECLINE
- ☐ ASIAN
- ☐ CAUCASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ AMERICAN INDIAN / ALASKA NATIVE
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

Ethnicity (Please check only one.)

- ☐ DECLINE
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ OTHER / UNDETERMINED

I attest that the pharmacy and laboratory information provided is true and accurate to the best of my ability. As a component of Electronic Prescribing, we need your consent to access your medication history from your pharmacies. Please sign your name below if you give your consent.

_____	_____	_____
SIGNATURE OF PATIENT	PRINTED NAME OF PATIENT	DATE