NEW YORK CARDIOLOGY ASSOCIATES P.C.

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

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

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

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Authorization to Use or Disclose My Health Information

Patient name: _____ **Date of birth:** _____

Address: _____ **Phone Number :** _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by _____
☐ My health information relating to the following treatment or condition: _____
☐ My health information for the date(s): _____
☐ Other: _____

You may disclose this health information to:

Name (or title) and organization _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Fax Number: _____

Reason(s) for this authorization (check all that apply):

☐ for my personal records
☐ for another health care provider
☐ changing health care provider
☐ other: _____

This authorization ends: ☐ on (date) _____
☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.

or

- To receive health care when the purpose is to create health information for a third party.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature **Date** **Witness**

_____ _____
Printed Name if signed on behalf of the patient **Relationship (parent, legal guardian, personal representative, etc.)**

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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:** _____

(NYCA 07/2024)