ALFIERI CARDIOLOGY, P.A.

701 Foulk Road, Suite 2B
Wilmington DE 19803

G-39 Omega Drive
Newark, DE 19713

2600 Glasgow Avenue, Suite 103
Newark, DE 19702

Telephone (302) 731-0001 Fax (302) 731-0040

PATIENT INFORMATION SHEET

Patient Name: _____ **Date:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Social Security No:** _____-_____-_____

Gender: _____ **Male** _____ **Female** **Marital Status:** _____**Married** _____**Single**

Home Phone: _____-_____-_____ **Work Telephone:** _____-_____-_____

Cell Phone: _____-_____-_____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other Declined

Primary Care Physician: _____**Physician Phone Number:** _____

Who may we contact in case of emergency?

Name: _____**Phone Number:** _____-_____-_____ **Relation:** _____

How did you hear about Alfieri Cardiology P.A.?
Friend Family Member Primary Care Physician Cecil Whig News Journal Other_____

WHAT YOU NEED TO KNOW

- **Read this notice, so you can make an informed decision about your care.**
- **Ask us any questions that you may have after you finish reading.**

Patients are responsible for the services rendered. Necessary forms (including referrals) will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also required that payment for co-payments is rendered at the time of service. I understand that if incorrect or improper insurance information or referrals are not obtained for my visit(s), my appointment may be cancelled and I may be billed for the amount(s) due on the account.

Patient Signature: _____ **Date:** _____

I request that payment of authorized Medicare/Other Insurance company benefits be made directly to Alfieri Cardiology P.A. on my behalf for any services furnished to me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature: _____ **Date:** _____

I give Alfieri Cardiology P.A. authorization to release information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim/ other Insurance Company claim. I understand that any or all of my medical information may be used for blinded-data research, in which none of the data will be linked to my identity. I understand that my medical information may be electronically submitted to any or all of my treating physicians, hospitals and/or medical benefits to the party who accepts assignment. If it is needed to provide my medical care, I grant permission for Alfieri Cardiology P.A. to view my prescription history as made available by Surescripts.

Patient Signature: _____ **Date:** _____

Advance Beneficiary Notice of Non-Coverage (ABN)

Note: If your insurance carrier does not pay for any services rendered by the provider, you will be responsible for the balance of the fees. Primary Health Insurance does not pay for every service provided, including some care that you or your health care provider have good reason to think you need. The provider of service will submit all claims to the insurance carrier(s) listed below in attempt to obtain an official decision on payment. However, if the insurance carrier(s) does not pay for services rendered, then the healthcare provider is not liable.

Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in your patient chart. If a claim is submitted to insurance carrier(s), your health information on this form may be shared with the payor as per federal guidelines.

Primary Insurance: _____ *Member ID or Policy #:* _____

Group #: _____ *Policy Holder Name:* _____

DOB: ____/____/_____ *Does your insurance require a referral?* _____*Yes* _____*NO* *Copayment:* *$*_____

Secondary Insurance: _____ *Member ID or Policy #:*_____

Group #: _____ *Policy Holder Name:* _____

DOB: ____/____/_____

Third Insurance: _____ *Member ID or Policy #:*_____

Group #: _____ *Policy Holder Name:* _____

DOB: ____/____/_____

***Medicaid does not pay for all your healthcare cost. Medicaid only pays for covered tests and services when Medicaid rules are met, based on your coverage program. If you are enrolled in a limited coverage program, you may be billed for non-covered services. Limited coverage guidelines apply.*

Medicaid Full/Limited Coverage Programs include: ***(please circle your plan)***

- ***Medicaid of DE***

○ *Full coverage*	○ *Family planning and related services*
○ *Chronic Renal Disease Program*	○ *Qualified Medicare Beneficiary*
○ *DE Healthy Children's Program*	○ *Long Term Care*
○ *DE Prescription Assistance*	○ *Hospice*
○ *DE Cancer Treatment Program*	○ *Transportation*

- ***Health Options (Blue Cross Blue Shield)***
- ***United Health Care Community Plan (UHC)***
- ***Diamond State Partners***

******Patient eligibility will be verified by the Healthcare Provider's Office******

Additional information: *Signing below means that you have received a copy of this noticed and understand it contents.*

Patient signature: _____ ***Date:*** _____/_____/_____

ALFIERI
CARDIOLOGY
PREVENTION & INNOVATION

Telephone (302) 731-0001
Fax (302) 731-0040

HIPPA (Health Insurance Portability & Accountability Act of 1996)
Acknowledgement of Privacy Practice Notice from
Alfieri Cardiology

By my signature below, I acknowledge receipt of the **HIPPA Privacy Practice** notice for Alfieri Cardiology:

_____ _____

Patient Name **Patient Signature**

_____

Date

If you have any questions about this notice or if you think we may have violated your privacy rights, please ask to speak to our **HIPPA Privacy Officer** or the office manager. If you wish to retain a copy of this Privacy Practice Notice for your records, one will be provided.

Please circle one:

Yes

No

(Stop Here)

THIS SECTION FOR OFFICE USE ONLY

The above named patient and/or representative has declined to sign the acknowledgement of receipt of the Privacy Practice Notice from Alfieri Cardiology.

_____ _____

Employee Name **Date**

Wilmington
701 Foulk Rd, Suite 1A
Wilmington, DE 19803

Omega
39 Omega Drive
Newark, DE 19713

Glasgow
2600 Glasgow Ave, Suite 103
Newark, DE 19702

ALFIERI CARDIOLOGY
PREVENTION & INNOVATION

PATIENT PORTAL NOW AVAILABLE!!!

Alfieri Cardiology would like you to join our new patient portal. Through the portal, you can:

- Send and receive non-urgent messages
- Request medication refills
- View lab and test results
- Request appointments and view scheduled appointments

Joining is easy. Simply supply your information below and you will receive an email invitation from IQHealth. The invitation expires in 90 days so please do not delay. Follow the link provided in the email to accept your invitation and create your account. When prompted for your shared secret, please enter your 5-digit zip code.

Name: _____

Date of Birth: _____

Email Address: _____

To be completed by office staff:

DOS: _____ MRN: _____

Payment Policy

Thank you for choosing Alfieri Cardiology as your healthcare provider. We are committed to providing you with quality and affordable health care. This policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

Insurance Coverage: We participate with most major insurance companies including Medicare and Medicaid. If we do not participate with your insurance company then payment is due at time of service. It is your responsibility to know and understand your insurance benefits. Please contact your insurance company should you have questions.

Proof of Insurance: All patients must provide a photo ID along with their insurance card. Failure to provide this information could result in non-payment of claims and become the patient balance. You are responsible for notifying us, prior to your visit, of any changes in insurance.

Referrals and Authorizations: Some insurances require a REFERRAL from your Primary Care Physician which you are responsible for providing at time of service. Some insurances require an AUTHORIZATION prior to services being rendered. Although we obtain the necessary authorization, it is not a guarantee of payment.

Copayments: Copayments are due at time of service. Failure to collect copayments constitute insurance fraud under federal and state regulations. For your convenience we accept cash, checks, Visa, MasterCard and Discover. If you do not pay your copayment your appointment may be rescheduled. A $10.00 service charge will be assessed each time a copay is not paid at time of service.

Patient Balances: All patient balances are due in full at time of service or immediately upon receipt of a statement. If payment is not made or a payment plan has not been established, then future services may be suspended. After 120 days the balance will be considered delinquent and may be forwarded to a collection agency. You will be charged a fee for any balances sent to collections. Should that occur you may be discharged from the practice. If discharged, you will receive written notification and have 30 days to find alternative care.

Missed Appointments: Appointments which are not cancelled within 24 hours prior to the scheduled time are considered a "no-show". We charge a fee for no-show appointments. Based on circumstances we may extend a one-time courtesy. However, you will be charged for future occurrences.

Claim Submission: We file both primary and secondary claims. Once all insurance has been processed, any remaining balances will become the patient's responsibility. We will make every effort to insure that your claims are processed and paid correctly. However, you may need to contact your insurance company directly.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand this payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

ALFIERI CARDIOLOGY
PREVENTION & INNOVATION

PATIENT INFORMATION

Patient Name:
LAST: **FIRST:** **MIDDLE INITIAL:**

Date of Birth
_____/_____/_____ **Marital Status:** _____ ❑ **MALE** ❑ **FEMALE**

Have you had any recent lab work? ❑ YES ❑ NO **Have you had any recent hospital stays?** ❑ YES ❑ NO
IF YES, PLEASE LIST:

_____

Do you have any allergies? ❑ YES ❑ NO
IF YES, PLEASE LIST:

_____

Are you a smoker? ❑ YES ❑ NO

IF NO: DATE STOPPED _____/_____/_____

Do you drink alcohol? ❑ YES ❑ NO

IF YES: ❑ OCCASIONALLY ❑ WEEKLY ❑ DAILY ❑ OTHER: _____

Have you ever used recreational drugs? ❑ YES ❑ NO

IF YES, PLEASE LIST:

_____

Family History: (IE: HEART DISEASE, HIGH BLOOD PRESSURE, CANCERS, DIABETES)

Mother: _____

Father: _____

EMPLOYMENT/SCHOOL:

- ❑ **EMPLOYED**
- ❑ **PART TIME**
- ❑ **RETIRED**
- ❑ **DISABLED**
- ❑ **UNEMPLOYED**
- ❑ **STUDENT**

EXERCISE:

FREQUENCY: _____ **EXERCISE TYPE:** _____

PLEASE LIST YOUR CURRENT MEDICATIONS WITH CURRENT DOSAGES

_____

_____

_____

Pharmacy Name: _____ City, Zip Code of Pharmacy _____

IF YOU HAVE A LIST OF YOUR MEDICATION PLEASE PROVIDE THE FRONT DESK WITH THE LIST TO BE COPIED. THANK YOU.