Holy Cross Medical Group

PATIENT INFORMATION RECORD

Allergies:_____ **Age:**_____

Patient's Legal Name: _____ Today's Date: _____
First M.I. Last

Address: _____
Street City State Zip

Phone #'s – Daytime:_____ Evening:_____ Emergency: _____ Cell:_____

Where do you prefer to receive calls?: ❑ Home Number ❑ Work Number ❑ Cell Number ❑ In Writing
❑ OK leave message with detailed info ❑ Leave message with call-back number only

Patient's Date of Birth:_____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partner Religion: _____ Primary Language: _____

Ethnicity: _____ Race: _____

Social Security No.:_____ – _____ – _____ Referred By: _____

Responsible Party: _____ Telephone: (___)- _____
First M.I. Last

Address: _____
Street City State Zip

Responsible Party Social Security No.:_____ – _____ – _____ Date of Birth: _____

Employer:_____ Telephone: (___)- _____

Address: _____
Street City State Zip

Next of Kin: _____ Relationship:_____ Telephone: Res:(___)-_____ Work:(___)- _____

I. INSURANCE INFORMATION:

Is Your Insurance a: ❑ PPO ❑ HMO ❑ Medicare ❑ Medicaid ❑ Other:_____

II. IS PATIENT'S CONDITION RELATED TO:

Employment (Current or Previous): ❑ Yes ❑ No Auto Accident: ❑ Yes ❑ No Other Accident: ❑ Yes ❑ No

PRIMARY

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Group Number:_____ Medicare/Policy Number: _____

Name of Insured:_____ Insured's Date of Birth:_____

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): _____

SECONDARY

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Group Number:_____ Medicare/Policy Number: _____

Name of Insured:_____ Insured's Date of Birth:_____

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): _____

*** * * * FOR OFFICE USE ONLY * * * ***

Identification Presented: ❑ Passport ❑ Driver's License ❑ State I.D. ❑ Insurance Card

Holy Cross Medical Group

MEDICARE AND MEDICAID SIGNATURE AUTHORIZATION

Medicare and Medicaid patient certification - patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or TITLE XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services. I request that this authorization apply to all claims, present and future. I understand that I am responsible for my health insurance deductible and coinsurance.

Date: _____

Print Patient's/Beneficiary's Name: _____

Patient's/Beneficiary's Signature: _____

****

COMMERCIAL INSURANCE, MANAGED CARE MEMBERS AND SECONDARY PAYOR AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf. I assign the benefits payable for physician services to the HOLY CROSS MEDICAL GROUP / HOLY CROSS HOSPITAL. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment of any balance not paid by my insurance company.

Date: _____

Print Patient's/Insured's Name (Parent's Signature if child): _____

Signature of Insured: _____

Patient's/Insured's Signature: _____

Holy Cross Medical Group

CARDIOLOGY ASSOCIATES OF BOCA RATON

MESSAGE CONSENT

David S. Funt, MD | Jay F. Baker, MD | Constance D. Fields, MD
Steven M. Coletti, MD | Ronald M. Gabor, MD | Rahonie Evans, ARNP

It is our policy to notify you of test results ordered by this office. This is to acknowledge that you authorize us to:

1. Leave a detailed message on your voicemail/answering machine.

_____YES _____NO

Best contact phone number is _____

2. If not at home, may we leave a detailed message with the individual listed below?

_____YES _____NO

Please name individuals that you hereby authorize on your behalf to speak with this office regarding all aspects of your medical chart, i.e. health conditions, test results, medications, financial history.

Name_____ Relationship_____

Address_____

PHONE_____

Name_____ Relationship_____

Address_____

PHONE_____

Patient Signature_____ Date_____

Print Patient Name_____

Holy Cross Medical Group

Date: _____ Patient Name_____ DOB_____

Holy Cross Hospital is now collecting information from patients during their office visit as part of the Meaningful Use healthcare initiatives put in place by the Federal Government. Listed below is the information that we are gathering to comply with the new program. If you would please take a moment to answer the following questions then hand this paper back to the front desk.

We thank you in advance for your time.

Standards for Maintaining, Collecting, and Presenting
Federal Data on Race and Ethnicity

This dassification provides a minimum standard for maintaining, collecting and presenting data on race and ethnicity for all Federal reporting purposes. The categories in this classification are social political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies. (http://www.whitehouse.gov/omb/inforeg statpolicy/#dr).

1. Which of the following do you consider yourself?

   ___Hispanic or Latino ___Not Hispanic or Non-Latino ___Decline ___Unknown ___Other

2. Which category best describes your race?

   ___Black, African American ___American Indian, Alaska Native ___Asian

   ___Native Hawaiian, Other Pacific Islander ___Pacific Islander ___White

   ___Chinese ___Filipino ___Hispanic ___Japanese ___Other ___Declined ___Unknown

3. Which language do you prefer to use to communicate?

   ___English ___French ___Creole ___Spanish ___Russian

   _____Portuguese _____Other

4. What communication method would you prefer the office to use when conveying medical information?

   Home Phone____-____-_____ Cell Phone_____-_____-_____

   Work Phone_____-____-_____ _____Postal Service (mailing) _____PO Box

5. How did you hear about us?

   _____Health Screening _____ Insurance Company _____Ad/TV/Internet

   _____Word of mouth _____another patient _____Physician referral

I have been given a copy of Holy Cross Hospital, Inc. Notice of Privacy Practices, version effective: **JULY 15, 2004**

Signature of Patient or Representative: _____ Date: _____

Print Name of Patient or Representative: _____

Relationship of Representative to Patient: _____

Please describe the Representative's authority to act on behalf of the Patient: _____

_____

_____

_____

* *

FOR HOLY CROSS HOSPITAL, INC. USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it: _____

_____

_____

_____

_____

He recibido una copia del Aviso de Prácticas de Privacidad del Holy Cross Hospital, Inc., versión vigente: **JULY 15, 2004**

Firma del Paciente o de su Representante: _____ Fecha: _____

Escriba el Nombre del Paciente o de su Representante: _____

Relación/parentesco entre Representante y Paciente: _____

Por favor describa la autoridad del Representante para actuar en nombre del Paciente: _____

_____

_____

_____

* *

PARA USO DEL HOLY CROSS HOSPITAL, INC. SOLAMENTE

Si no pudo obtener del paciente, o de su representante, un acuso de recibo del Aviso de las Prácticas de Privacidad, por favor explique los pasos que siguió para obtener el mismo y las razones por las cuales no pudo obtenerlo: _____

_____

_____

_____

_____

Holy Cross Medical Group

ADVANCE MEDICAL DIRECTIVE

Many people have become aware that medicine today has the ability to keep people alive for extended periods of time, even in hopeless situations. For many, this is a great concern and question, how can you be sure this does not happen to you? If you are at least 18 years of age and of sound mind, there is something you can do to make your wishes known. You have the right to execute an Advance Directive/Living Will. An Advance Directive is a witnessed statement, usually written and made in advance of a future event, that states a person's wishes about what life-sustaining treatments would be wanted if he/she became incapacitated and unable to express his/her wishes. There is no legal requirement to complete an Advance Directive. However, if you have not made an Advance Directive or Designated Healthcare Surrogate, healthcare decisions may be made for you by a court appointed guardian, your spouse, adult child, your parent, your adult sibling, an adult relative or a close friend, in that order. This person would be called a proxy.

DO YOU HAVE A LIVING WILL?

* ❑ YES ❑ NO

WOULD YOU LIKE TO HAVE A LIVING WILL?

* ❑ YES ❑ NO

Patient's Name: _____

Patient's Signature: _____

Date: _____

*** If you have a Living Will or Advance Directive, or plan to have one in the future, it is your responsibility to provide this office with a copy so that we may abide by your directives.**

Holy Cross Medical Group

Holy Cross Medical Group, an outpatient Division of Holy Cross Hospital

Tips to understand Medicare Split Billing

Holy Cross Medical Group is a department of Holy Cross Hospital. Each Holy Cross Medical Group physician is an employee of Holy Cross Hospital.

Every Holy Cross Medical Group office located throughout our community is classified by Medicare as a satellite outpatient clinic of Holy Cross Hospital. Each of our offices must maintain the same standards as the Hospital.

Because each office location is considered an extension of Holy Cross Hospital, Medicare regulations require that we separate, or split, the services you receive into two bills.

1. Medicare Part B pays for physician services, meaning your physician's time and professional expertise.
2. Medicare Part A pays for hospital based services, including the costs associated with operating a physician office or clinic and technical costs such as labs, x-rays, and injections.

Although we generate two bills to comply with Medicare regulations, the total of the two bills to Medicare is the same as the total of the one bill that we submit to each of our other insurance payors.

Remember that this split billing to Medicare is because Holy Cross Medical Group is a department of Holy Cross Hospital and are considered to be satellite locations of the Hospital.

The impact of split billing to you as a patient:

1. Your services for one date of service will be divided into two components. Medicare B will pay for the physician cost. Medicare A will pay for the technical costs.
2. Your secondary insurance will receive two bills. One for the 20 % coinsurance amount due under Medicare part B for the physician costs and one for the coinsurance amount due under the Medicare Part A for the technical costs. It is possible that the coinsurance amount due under Medicare Part A could exceed that of a physician not affiliated with a hospital, but will approximate 20 %.
3. If you do not have a secondary insurance or your secondary insurance does not respond, your co-payment requirement will be billed to you in two pieces. One will represent the 20 % due under Medicare Part B for the physician costs and one for the co-payment amount due under Medicare Part A for the technical costs.

   Again, it is possible that the coinsurance amount due under the Medicare Part A could exceed that of a physician office not affiliated with a hospital, but will approximate 20 %.

We understand that the split billing to Medicare is confusing. If you have any questions about the statements you receive from us, please call our Patient Financial Services Representatives at **954-596-8002**. We appreciate the faith that you have put in us as your health care providers and thank you for your loyalty to Holy Cross.

Signature_____ **Date**_____/_____/_____

Off Campus Medicare Outpatient Coinsurance Notice

To our Medicare patients:

Medicare regulations require us to provide you with a notice of your potential financial liability for the hospital service(s) you will receive.

We are required to advise you that because the service(s) is/are furnished by a department of the hospital, you will incur a coinsurance liability to the hospital that you would otherwise not incur if the services were furnished in an entity that is not hospital-based. At this time, we can provide you with the following information on the estimated amount of your coinsurance liability.

- Your coinsurance liability for the hospital service(s) is estimated to be $_____, based on our current information about scheduled services.
- Since we do not know the exact type and extent of services that you may need, we are unable to provide you with an estimate of your liability. However, the typical charge incurred by a benficiary based on all visits to this department or facility normally ranges between $ 13.73 and $45.19

The actual amount of your coinsurance liability to the hospital may be different from any estimate that is provided above. Actual coinsurance liability will be based on the services that you receive and also subject to final determination by the Medicare program.

If you are enrolled in a state medical assistance program such as Medicaid, your coinsurance liability may be reduced or eliiminated by law.

Your coinsurance liability for hospital services is separate from the Medicare coinsurance liability that you may owe for any physician or professional services provided to you in conjunction with hospital services.

I have read the forgoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law.

_____

Signature of patient or authorized representative

MM / DD / YR
Date

HCH FORM # 2462 (4/2013)

Holy Cross Medical Group

Holy Cross Medical Group, an Outpatient Division of Holy Cross Hospital