



# PATIENT INFORMATION RECORD

Age: \_\_\_\_\_

Allergies: \_\_\_\_\_

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: \_\_\_\_\_

Email Address: \_\_\_\_\_

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

<b>PRIMARY</b>	INSURANCE COMPANY NAME: _____
	Address: _____ Street City State Zip
	Group Number: _____ Medicare/Policy Number: _____
	Name of Insured: _____ Insured's Date of Birth: _____
	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Student over 18
	Other (Please describe): _____

<b>SECONDARY</b>	INSURANCE COMPANY NAME: _____
	Address: _____ Street City State Zip
	Group Number: _____ Medicare/Policy Number: _____
	Name of Insured: _____ Insured's Date of Birth: _____
	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Student over 18
	Other (Please describe): _____

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

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



**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. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.v

Date: \_\_\_\_\_

Print Patient's/Beneficiary's Name: \_\_\_\_\_

Patient's/Beneficiary's Signature: \_\_\_\_\_

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**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. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.

Date: \_\_\_\_\_

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

Signature of Insured: \_\_\_\_\_

Patient's/Insured's Signature: \_\_\_\_\_



## CARDIOLOGY ASSOCIATES OF BOCA RATON MESSAGE CONSENT

David S. Funt, MD  
Steven M. Coletti, MD

Jay F. Baker, MD  
Ronald M. Gabor, MD

Constance D. Fields, 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 \_\_\_\_\_

I have been given a copy of Holy Cross Hospital, Inc. Notice of Privacy Practices, version effective: **September, 1, 2017**

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**FORM #400-020A**  
03/2018 Front / English  
Page 1 of 1

PATIENT LABEL



## 24 Hour Cancellation & “No Show” Fee Notice

Recognizing that everyone’s time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the Physicians of Holy Cross Medical Group reserve the right to charge a fee of \$25.00 for each missed (No Show) appointment, which is, absent for a compelling reason, and is not cancelled within a 24 hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple “No Shows” in any 12 month period may result in termination from our practice.

Thank you for you anticipated cooperation.

*By signing below, you acknowledge that you have received this notice and understand this policy*

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Printed - Guardian or Parent Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## 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.**

DOB: \_\_\_\_\_ MRN# \_\_\_\_\_

## 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 beneficiary based on all visits to this department or facility normally ranges between \$ \_\_\_\_ **23.00** and \$ \_\_\_\_\_ **74.00** \_\_\_\_\_

The actual amount of your coinsurance liability to the hospital may be different from any estimate is provided above. Actual coinsurance liability will be based on the services that you will 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 eliminated 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.

X \_\_\_\_\_

Signature of patient or authorized representative

Date



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



## **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 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 copayment 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 provides and thank you for your loyalty to Holy Cross.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_