

Saratoga Cardiology Associates, PC

6 Care Lane
Saratoga Springs, NY 12866

Phone: (518) 587-7625

Andrij O Baran, MD FACC

Roland T Phillips, MD FACC

David D Kandath, MD FACC

Harold G Card Jr, MD FACC

William M Kufs, MD FACC

Nicholas I Kondo, MD FACC

Stephen J Dempsey, Jr, MD FACC

Theodoros Laddis, MD FACC

Patient:

Account:

DOB:

Soc Sec#:

Thank you for choosing Saratoga Cardiology for your cardiac care. We would like to welcome you to our practice. Please complete the attached form for our records and bring it with you to your appointment.

Please arrive 15 minutes early for your appointment. Any insurance that requires a patient co-payment will be collected when you check-in. A surcharge will be instituted if you fail to do so. For your convenience Saratoga Cardiology Associates accepts all major credit cards, cash or personal checks. If you are required by your insurance company to have a referral for a specialist visit please bring that with you to your appointment. Please bring your insurance cards with you for registration.

In the event that you cannot keep your scheduled appointment we require a 24 hour cancellation notice or a surcharge will be billed to you personally.

All professional services rendered, regardless of participating agreements, are submitted to your insurance company as a courtesy to you. Deductibles and co-insurances are your responsibility. Patients with non-participating insurances will be responsible for their account balances. If your insurance company requires you to pay a copayment, it is due at the time of service. Copayments not received at the time of service are subject to a \$10.00 service charge.

If there are any questions concerning insurances, please call our billing office at 693-0294 between 8:00 am and 4:00 pm Monday through Friday.

We are looking forward to meeting you.

Office Hours: 8:00am-5pm Monday thru Friday

Testing Hours: 6:30am-5pm Monday thru Friday

Telephone Hours: 8:00am-5pm Monday thru Friday

Saratoga Cardiology observes the following holidays:

New Years Day or preceding/following business day if holiday is on a weekend

Memorial Day

4th of July

Labor Day

Thanksgiving Day and the day after

Christmas Day or preceding/following business day if holiday is on a weekend

The physicians at Saratoga Cardiology are on call for medical emergencies 24 hours a day, 7 days a week including weekends and all holidays.

**Please complete the attached forms and give them to the receptionist at time of check in.

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PATIENT INFORMATION:

Patient's Email address: _____
Patient's Employer: _____ Phone #: _____
Address: _____ City: _____
State: _____ Zip: _____ Race: _____ Ethnicity: _____
Next of Kin in Case of Emergency: _____
Number(s) where they can be reached from 8am-6pm _____
Primary Care Physician: _____

PRIMARY INSURANCE INFORMATION: (Please bring your Insurance Card)

Carrier Name: _____ ID: _____ Group#: _____
Policy Holder Name: _____ DOB: _____ SS#: _____
Relationship to patient (circle one): Spouse Child Other (specify): _____

SECONDARY INSURANCE INFORMATION: (Please bring your Insurance Card)

Carrier Name: _____ ID: _____ Group#: _____
Policy Holder Name: _____ DOB: _____ SS#: _____
Relationship to patient (circle one): Spouse Child Other (specify): _____

WORKERS COMP/NO FAULT INSURANCE INFORMATION:

Carrier Name: _____ Phone#: _____
Address of Carrier: _____
Date of Injury/Accident: _____
Name of Adjustor/Case Manager _____ Case#: _____

PERSON RESPONSIBLE FOR PAYMENT, IF NOT THE PATIENT:

Name: _____ Date of Birth: _____
Relationship to patient (circle one): Spouse Child Other (specify): _____
Address (if different from patient): _____
City _____ State: _____ Zip: _____ Home Phone: _____
Employer of person responsible for bill: _____
Address: _____ City: _____
State: _____ Zip: _____ Work Phone: _____

I authorize Saratoga Cardiology Associates to furnish information to insurance carriers concerning my illness and treatment and I assign to the physician all payments for medical services rendered to myself or my dependents.

Signature: _____ Date: _____

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LIST OF CURRENT MEDICATIONS WITH DOSE: Please bring a list of current medications to each visit

PREVIOUS SURGERIES WITH DATES: Please list below in the space provided or use the backside if necessary.

LIST OF SPECIALIST SEEN WITH DATES: Please list below in the space provided. Please call your specialist and obtain records to bring with you for your appointment or request they be faxed to 518-587-6665 before your appointment date. (use backside if necessary)

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Request For Release of Medical Information

I hereby request that my medical records be forwarded to:

Attn: Medical Records Department
6 Care Lane
Saratoga, NY 12866

Please include the following:

____ History and Physical, Progress Notes

____ Lab and Radiology Reports

____ Pertinent Correspondence

____ Other: _____

I was your patient from _____ to _____.

Patient Name:

Address:

Phone:

Patient DOB:

SS#:

Signature:

Date:

Requesting Information From:

Date Requested: _____ **Witness Initials:** _____

HIPAA RELEASE FORM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) was enacted in 1996. This act provides for, among other things improved portability and continuity of health insurance coverage in the group and individual markets, and group health plan coverage provided in connection with employment.

HIPAA was designed to standardize several different aspects of the health administration field. Some of these standardized fields will include security, privacy, billing and fraud and abuse control.

Saratoga Cardiology administers these practices on a daily basis already, and will continue to implement necessary changes to ensure the highest quality of care possible for our patients. In order to do this we are requesting you sign below "shared information release form." By filling out the below information, Saratoga Cardiology will be able to discuss your personal information (medical) with the indicated party listed below. Without an identified member on your account, "NO" medical information will be discussed with anyone except the patient. Feel free to direct any questions regarding this to the HIPAA Officer Pat Ramsey.

Shared information release form/release of medical records form

I give permission to Saratoga Cardiology Associates to discuss any information regarding my medical care concerning myself, to the individual listed below. I take full responsibility in notifying Saratoga Cardiology in the event that my personal circumstances may change, altering my contact person. Changes to the contact form can be made at any time in person or via a written document. You may not change or add contacts over the telephone. I may revoke this consent in regards to the release of my medical records at any time, understanding that records may have been sent in the interim.

This signature will also allow Saratoga Cardiology to release my necessary medical information to my primary care physician and any providers whom are partaking in my medical care, as well as insurance companies, and authorizes direct payment of medical benefits to the physicians within the group for services rendered and acknowledges that I am responsible for all unpaid balances.

You may release my information to:

1ST Contact Name: _____ DOB: _____ Relationship: _____

2nd Contact Name: _____ DOB: _____ Relationship: _____

Patient Name: _____ Patient DOB: _____

Patient Signature: _____ Date: _____ Witness: _____

The above signature also acknowledges the receipt of Saratoga Cardiology Associates Notice of Privacy Practice. If you would like a copy of our policy please request one from our receptionist.