

• PATIENT INFORMATION FORM •

PLEASE PRINT CLEARLY

Today's Date:

Name:

Date of Birth:

Address:

Your age:

Gender:

City:

Marital Status:

State:

Zip:

Email Address:

Employer:

Your occupation:

Do you have a living will?: Yes No

YOUR CONTACT INFORMATION

Home Phone:

Cell:

Work:

Do you give permission to Abington Medical Specialists to leave messages on your answering machine or voicemail?

Yes No If yes, which phone no.: Home Cell Work

Which number do you prefer to be contacted on: Home Cell Work

Please note: New Healthcare regulations require us to obtain the following information:

Ethnicity:

Caucasian

African American

Hispanic

Language Spoken: English Korean

American Indian

Native Hawaiian

Hindi Spanish

Asian

Other Pacific Islander

If other language, please specify:

Other Ethnicity:

Do you require a foreign language interpreter present at your appointment with our doctor? Yes No

EMERGENCY CONTACT INFO

I give permission for Abington Medical Specialists (AMS) to discuss my healthcare with the following person(s):

1) Name:

Phone:

Relationship:

2) Name:

Phone:

Relationship:

FAMILY PHYSICIAN & PHARMACY INFORMATION

Name:

Phone:

Address:

City:

State:

Zip:

Your Pharmacy Name:

Phone:

Who referred you to AMS Cardiology:

INSURANCE INFORMATION

Insurance Company:

Policy No:

Group No:

Insurance Address:

Subscriber's Name:

Subscriber's DOB:

Subscriber's Employer:

Phone:

Your relationship to Subscriber: Self Spouse Parent Other (specify)

I acknowledge that I received or was offered a copy of the AMS Privacy Act (HIPAA): Initials

<<< Please also complete the reverse side of this form >>>

version 2.6

AUTHORIZATIONS

ALL NEW AMS PATIENTS FILL OUT THIS SECTION:

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or to another physician's office.

I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance, and any other health plan to Abington Medical Specialists.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges, whether or not paid by insurance.

*

Signature of patient or responsible party

Date

MEDICARE PATIENTS ONLY, FILL OUT THIS SECTION:

I request that payment of authorized Medicare benefits be made to me or on my behalf to Abington Medical Specialists for any services furnished to me by Abington Medical Specialists. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

*

Signature of Medicare Patient

Date

I request that payment of authorized Medicare Supplemental benefits be made to either me or on my behalf to Abington Medical Specialists for any services furnished me by that physician/supplier. I authorize any holder of Medicare information about me to release to _____ any information needed to determine these benefits payable for related services.

*

Medicare Beneficiary Signature

Date

In compliance with Medicare regulation, we ask that you answer the following questions:

Do you or your spouse work for a company that provides you with health insurance? ___ yes ___ no

Are you entitled to Medicare because of disability or End Stage Renal Disease? ___ yes ___ no

Is the illness or injury the result of an automobile accident or other injury? ___ yes ___ no

Has treatment for the accident or illness been authorized by the Veteran's Administration? ___ yes ___ no

Are you entitled to any benefits under the Federal Black Lung Program? ___ yes ___ no

I certify that this information is true and complete to the best of my knowledge. ___ yes ___ no

*

Signature

Date

CARDIOVASCULAR HEALTH QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of Birth: _____

Family Physician: _____ Smoking History: _____

Occupation: _____

Drug Allergies: (list medications and symptoms caused): _____

Please list current medications, including any vitamins & supplements:

Previous Surgery: (list operations and dates)

Family History:	Living	Deceased	Cause of Death	Illnesses
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

Do you have any of the following?

Yes

No

If yes, for how long?

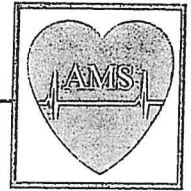
Chest Pain: ____ at rest or ____ with exercise	_____	_____	_____
Shortness of Breath	_____	_____	_____
Diabetes (or abnormal blood sugar)	_____	_____	_____
Increased or abnormal blood pressure	_____	_____	_____
Swelling of the Legs or Feet	_____	_____	_____
Pain in the Calves when Walking	_____	_____	_____
Heart Murmur	_____	_____	_____
History of Rheumatic Fever	_____	_____	_____
Palpitations (skipped heart beats or "rapid heart action")	_____	_____	_____
Passing out or Black-out Spells	_____	_____	_____
Have you ever had a "Heart Attack"?	_____	_____	_____
Have you ever been told you had an "Abnormal EKG"?	_____	_____	_____
History of Lung Disease	_____	_____	_____
History of Bleeding Disorder or Internal Bleeding	_____	_____	_____

Do you have an inserted device like an ICD, pacemaker or defibrillator? If so, please indicate brand:

_____ St. Jude	_____ Medtronic
_____ Boston Scientific	_____ Biotronic

Other (or unknown): _____

What single complaint bothers you the most?
 (Please use reverse side or below if more room is needed) _____



Record Request Form from AMS Cardiology

Medical Record Fax Line: 215-376-1705

Please Print:

I, _____
(patient name)

hereby request that _____
(name of doctor)

send copies of the following records pertaining to my health care:

(Important: please initial the line in front of each item you would like to be sent*)

- _____ 1. Office notes and related reports including any hospital summaries / data
- _____ 2. Communications in my records from other physicians, including consultants.
- _____ 3. List any specific items to be sent that are not covered by items 1 & 2:

List any items that should NOT be sent, if applicable: _____

Send Records to: _____

Or Fax to: _____ Attn: _____

~~*~~ Your Signature: _____

~~*~~ PRINT NAME: _____

~~*~~ Date of Birth: _____

Date of Request: _____

*without initials, only data included in item #1 will be sent

AMS Cardiology Main Office • 118 Welsh Road, Unit B • Horsham, PA 19044

Levy Medical Plaza • 1235 Old York Road, Suite #110 • Abington, PA 19001

Montgomeryville Office • 1010 Horsham Road • Suite #214 • North Wales, PA 19454

Stein Medical Office Bldg. • 205 Newtown Road, Suite #216 • Warminster, PA 18974

ABINGTON MEDICAL SPECIALISTS, P.C.

PATIENT: _____

Date: _____

Thank you for choosing Abington Medical Specialists (AMS) as your provider. We are committed to providing you with the best available care. We ask that all responsible parties read and sign our financial policy. If you have any questions please feel free to ask our staff to discuss any fees or this policy with you. As the responsible party, please understand:

1. AMS will bill your insurance company on your behalf; however, you are ultimately responsible for the bill. Please communicate any problems to us so that we may assist you.
2. You are financially responsible for any balance not covered by your insurance carrier.
3. Co-payments, co-insurances and deductibles are due at the time of your visit. We cannot waive your insurance plan's requirements as we would be in violation of our contract.
4. You are required to pay your portion of any surgery/procedure prior to the procedure date. AMS will provide you with an estimate of your financial responsibility when possible and a date which payment is due. We will work with you to set up a feasible payment plan.
5. Please inform the receptionist of any changes in your address, phone number, insurance coverage.
6. You are responsible for providing a referral from your primary care physician should the insurance require one. If your insurance company denies payment due to non referral, you, the patient, agree to pay AMS in full for any charges incurred during the visit.
7. If you fail to make any payment which you are responsible for, your account may be turned over to a collection agency. You will be responsible for payment of reasonable collection and legal fees.
8. In the event that a check is returned, you are responsible for the amount of the check plus \$25.00 bank charges. Payment will then need to be made by cash, money order, or credit card.
9. The completion of disability and/or FMLA forms are not billable/reimbursable by insurance companies, therefore charges are your responsibility. AMS fees related to completion of these forms are \$15.00 per form.
10. Confirmation phone calls are made to patients 48-72 hours prior to your appointment as a courtesy reminder of your scheduled appointment. This reminder give you time to cancel and/or reschedule if you cannot keep the appointment. Cancellation must be done 24 hours in advance so that we may accommodate other patients. **There will be a \$50.00 charge to New Patients who do not show for the appointment or who do not give at least 24 hours notice. Established patients may be charged \$25.00 for not showing for appointments.**

Abington Medical Specialists is authorized to release to my insurance company(s) any necessary information needed to file and expedite payment of my claims. Assignment of any benefits should be payable on my behalf to Abington Medical Specialists.

Print Name _____ D.O. B _____

Signature or legal representative

Date