PATIENT INFORMATION

DATE: _____ MRN# (office use only)_____

FULL NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE# _____SS#_____

CELL # _____ FAX# _____

Email _____

MARITAL STATUS_____DATE OF BIRTH_____

MOTHER'S FIRST NAME_____ FATHER'S FIRST NAME_____

EMPLOYER'S NAME & ADDRESS_____

EMPLOYER'S TELEPHONE_____ EXT: _____

SPOUSE'S FULL NAME_____DATE OF BIRTH_____

EMPLOYER'S NAME & ADDRESS_____

_____

TELEPHONE_____SS#_____

FOR EMERGENCY CONTACT ONLY:

NAME & RELATION TO PATIENT_____ TEL#_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____

POLICY HOLDER_____ID#_____

MAILING ADDRESS & TELEPHONE_____

_____

SECONDARY INSURANCE_____

POLICY HOLDER_____ID#_____

MAILING ADDRESS & TELEPHONE_____

_____

LOCAL CARDIOLOGIST'S NAME _____

ADDRESS & TELEPHONE_____

PHARMACY NAME & NUMBER_____

PLEASE NOTE: ASSISTANT SURGEONS MAY BE USED AND REQUIRED

ASSIGNMENT OF BENEFITS AND RELEASE INFORMATION

THE MEDICARE PATIENT: I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO ME OR ON MY BEHALF TO THE PROVIDER(S) LISTED BELOW FOR ANY SERVICES FURNISHED ME BY THIS PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO HCFA AND IT'S AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS AUTHORIZATION IS IN EFFECT UNTIL I CHOOSE TO REVOKE IT. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

THE NON-MEDICARE/COMMERCIAL PATIENT: I AUTHORIZE PAYMENT BE MADE TO THE PROVIDER(S) LISTED BELOW. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____

PATIENT SIGNATURE DATE

Providers: DR's. C.Smith; M.Oz; Y.Naka; M.Argenziano; H. Spotnitz; H.Takayama;Isaac George, M.Borger, Syed T. Raza, Barry Esrig, Koji Takeda,PA's- Thomas Cosola, R-PA; M.Flannery, FNP; R.Te-Frey, FNP; J.Murphy; M.Finelle Torres, M. Tiburcio; Dana Reed ACNP, M.Duffy, K.Ross, M. Powers, M. Tsukashita

Authorization for Appeals

Date: _____

Patient Name: _____Social Security #_____

Date of Birth: _____ Insurance Co. Name: _____

_____

I authorize the provider(s) listed below and his billing staff to appeal any claim(s) for service(s) rendered on my behalf. I understand that there will be circumstances that will prevent the provider(s) of service from appealing the claim(s) in question and that it will be my responsibility to appeal with the insurance company directly. This authorization will be valid from the date of signature. If I decide to revoke this authorization the provider of service will be notified in writing.

_____ _____

Policy holders Signature

Policy holders Social Security #

_____ _____

Policy holders Date of birth

Date

Providers: **Providers: DR's. C.Smith; M.Oz; Y.Naka; M.Argenziano; H. Spotnitz; H.Takayama;Isaac George, M.Borger, Syed T. Raza, Barry Esrig, Koji Takeda,PA's-Thomas Cosola, R-PA; M.Flannery, FNP; R.Te-Frey, FNP; J.Murphy; M.Finelle Torres, M. Tiburcio; Dana Reed ACNP, M.Duffy, K.Ross, M. Powers, M. Tsukashita**

ColumbiaDoctors

Patient Payment Policy

Patient Name:_____ MRN #_____ Date:_____

Thank you for choosing the Department of SURGERY at Columbia University Medical Center. We understand that many patients find insurance coverage and financial responsibility issues complex and confusing so we have outlined our practice's policy. If you have any questions about our policies, our staff will be happy to assist you.

What Is My Financial Responsibility?

Your financial responsibility depends on a variety of factors, explained below.

Payment for Office Visits and Services

(1) If You Have...	(2) You Are Responsible For...	(3) We Will...
Managed Care or Commercial Indemity insurance plan and the provider is not a participating provider or benefits are considered out-of-network.	Paying 100% of the provider's full charges.	Submit an insurance claim to your insurance carrier on your behalf.
Managed care plan and the physician is a participating provider or benefits are considered in-network	Obtaining referral authorization, if applicable Paying your deductible, copayments and any other financial obligation as stated in your plan	Inform you of any services not covered by your plan. Submit an insurance claim to your insurance carrier
Traditional Medicare	Paying your deductible if it is not yet met for the calendar year, as well as any services not covered by Medicare. If you do not have secondary coverage or Medigap, you will also be asked to pay the 20% Medicare coinsurance.	Submit the Medicare claim, as well as any claims to your secondary insurance. For services that may not be covered by Medicare provide you with a Medicare ABN or Waiver for signature.
Traditional Medicaid	Area Specific: Generally, you are responsible for no payment when the physician's office accepts Medicaid. If Medicaid is not accepted, you may be responsible for the visit charge upfront.	If Medicaid is accepted in your physician's office, we will bill Medicaid. If Medicaid is not accepted, we will collect the visit charge upfront.
Worker's Compensation or No Fault	Providing to our staff a valid case number, accident date, insurance name and address, adjuster name and phone number. Providing authorization for the service if needed. Providing an AOB form for your No Fault carrier. No payment is due at the time of service.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
Uninsured	Paying 100% of the provider's full charges	Work with you to settle your account.

Patients Who Are Minors

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages, or must provide complete and accurate information about the guarantor on the insurance that will be billed.

Agreement Confirmation

I have read, understand, and agree to this Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayment and deductible are my responsibility and are payable immediately upon receipt of patient statement.

I authorize my insurance benefits be paid directly to TRUSTEES OF COLUMBIA UNIVERSITY

I authorize the Department of SURGERY at Columbia University Medical Center to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____ _____ _____

Patient or Guarantor Printed Name *Patient or Guarantor Signature* *Date*

ColumbiaDoctors

The Physicians and Surgeons of Columbia University

The Federal Government requires us to ask these questions. This information is used to track illnesses by age, gender, race and ethnicity. We will also use this information to identify the needs of different patient groups and develop plans to address them and monitor the quality of our services for all patients so everyone gets the highest quality care regardless of their racial or ethnic background. We ask that you check one box under each category and thank you for taking the time to complete this information.

Name: _____ **Date of Birth:** _____

MRN#: _____ **Visit Date:** _____

Ethnicity:

- ☐ Decline Response (I do not wish to answer)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ Decline Response (I do not wish to answer)
- ☐ American- Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other

Preferred Language:

- ☐ Decline Response (I do not wish to answer)
- ☐ ARABIC
- ☐ CHINESE
- ☐ CZECH
- ☐ DUTCH
- ☐ ENGLISH
- ☐ FRENCH
- ☐ GERMAN
- ☐ GREEK
- ☐ HEBREW
- ☐ HINDI
- ☐ INDONESIAN
- ☐ ITALIAN
- ☐ JAPANESE
- ☐ KOREAN
- ☐ MALAY
- ☐ Other
- ☐ PERSIAN
- ☐ POLISH
- ☐ PORTUGUESE
- ☐ ROMANIAN
- ☐ RUSSIAN
- ☐ SIGN LANGUAGE
- ☐ SLOVAK
- ☐ SPANISH
- ☐ SWAHILI
- ☐ TAGALOG
- ☐ THAI
- ☐ TURKISH
- ☐ URDU
- ☐ VIETNAMESE
- ☐ YIDDISH

Staff: please enter information in IDX and shred document. Do not scan into CROWN

WHOM CAN WE DISCUSS YOUR MEDICAL INFORMATION WITH?

Surgeon Name:_____

Surgery Department:_____Cardiothoracic Surgery_____

Patient Name:_____

PLEASE DESIGNATE FAMILY AND FRIENDS WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

Designated party:_____Relation to Patient:_____

Designated party:_____Relation to Patient:_____

Designated party:_____Relation to Patient:_____

Designated party:_____Relation to Patient:_____

1. I understand that I can revoke this authorization at any time. Initial_____
2. I understand that my treatment cannot be conditioned on whether I sign this authorization. Initial_____

_____ _____

Signature of patient or patient's representative Date

Date:_____

Division of Cardiothoracic Surgery

Patient Name_____Age_____

Which surgeon are you here to see?_____

Referring Cardiologist_____

Reason for Visit_____ Height_____Weight_____

Allergies_____

Please list all Current Medications/Vitamins/Supplements AND daily dose*:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

**Continue on the back of this page if you need more room*

Tobacco and Alcohol Use	
Use of tobacco/cigarettes? ☐ No ☐ Yes ☐ Current *# of years* _____ *#Packs/day* _____ ☐ Former *Year quit?*_____ *#Packs/day* _____	Use of alcohol or illegal drugs? ☐ No ☐ Yes ☐ Never or Drug type_____ How many drinks per week_____

General Medical/Surgical History

Have you ever had surgery of any kind? ☐ No ☐ Yes (describe and give year)

Have you ever had vein stripping? ☐ No ☐ Yes (describe and give year)

Please answer whether you have/had:		**If yes, please describe**
Cancer	☐ Yes ☐ No	
Easy Bruising?	☐ Yes ☐ No	
Previous blood transfusion?	☐ Yes ☐ No	
Frequent urination	☐ Yes ☐ No	
Difficulty urinating	☐ Yes ☐ No	
Thyroid disease	☐ Yes ☐ No	

Name:_____

Division of Cardiothoracic Surgery

Kidney disease	☐ Yes ☐ No	
Liver disease/Hepatitis	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	Date of onsent_____ Insulin? ☐ Yes ☐ No
Stroke	☐ Yes ☐ No	
Asthma/Lung disease	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

CARDIAC HISTORY

Heart Murmur	☐ Yes ☐ No	
Endocarditis	☐ Yes ☐ No	
Rheumatic Fever	☐ Yes ☐ No	
Irregular Heart Rhythm	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No	
HIgh Cholesterol	☐ Yes ☐ No	
Heart Attack	☐ Yes ☐ No	
Congestive Heart Failure	☐ Yes ☐ No	
Abnormal EKG	☐ Yes ☐ No	
Ankle Swelling	☐ Yes ☐ No	
Chest Pain	☐ Yes ☐ No	
Shortness of Breath	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

		Heart Disease?	Age	Cause of death if deceased
Mother	Alive ☐ Yes ☐ No	☐ Yes ☐ No		
Father	Alive ☐ Yes ☐ No	☐ Yes ☐ No		
Brother	Alive ☐ Yes ☐ No	☐ Yes ☐ No		
Sister	Alive ☐ Yes ☐ No	☐ Yes ☐ No		

Cardiac Procedures

Test	When	Where
Echocardiogram		
Stress Test		
Cardiac Catheterization		
Stent		
Pacemaker		Make/Model:
Defibrillator		Settings:

THANK YOU!

COLUMBIA UNIVERSITY
MEDICAL CENTER

PLEASE READ:

Assistant Surgeons: To ensure that you receive the best possible care and treatment, a medical professional might need to assist your surgeon during your procedure, if a resident is not available. The charges for an assistant surgeon are usually an additional 50 percent of the primary surgeon's fee, however, they are separate from the surgeon's charges. If there is an Assistant Surgeon who does not participate with your insurance, we will submit the bill to your insurance company for reimbursement and will balance bill you for a portion, which is not covered by your insurance carrier.

Please note that even though your surgeon feels that an assistant is necessary during your procedure, your insurance plan might deny the charges because they think an assistant surgeon is not "medically necessary." We will ask you to help us with the appeal process in hopes to secure additional funds and lower your out of pocket expense. (The financial associate in your physician's practice can further explain this.)

My signature below confirms that I have read the information above.

Signature: _____

Date: _____

COLUMBIA UNIVERSITY
MEDICAL CENTER

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #22, 2nd Floor
New York, NY 10032/ T(212) 342-0059 F(212)342-5173
http://www.cumc.columbia.edu/hipaa/

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____
Personal Representative (Print) Personal Representative's Signature

_____
Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

_____ _____
Employee Name Date

This form should be placed in the patient's medical record

Revised October 2007