Medical Information Communication Preferences

Patient Name: _____ **DOB:** _____

As our patient we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as labs, test results or appointments, to you and/or others involved in your care. Please note that appointment reminder "telephone calls or text" may be left at the contact number(s) or email you list below. Please list your email address to receive online healthcare information provided by Premier Heart patient secure portal or secure email.

Please indicate your communication preferences below:

By listing number(s)/or email(s) below you are giving Premier Heart permission to leave medical information pertaining to you, your dependent, or child.

Method	Area Code + Phone Number	Leave Voice Message or Email Please circle yes or no
Home Telephone		YES or NO
Mobile phone		YES or NO
Work phone		YES or NO
Email		YES or NO

Without specific permission, we will not release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relation to you (i.e. spouse, parent, son, daughter, partner, etc.) below if you would like medical information released to anyone other than yourself. Please check yes if a message with medical information can be left at the number you list below.

Name	Relationship (i.e. spouse, parent, son daughter, etc.)	Area Code, Phone #, extension	**OK** to leave a message
			Yes or No
			Yes or No
			Yes or No
			Yes or No
Comments:			

I assume the responsibility to inform the practice of any changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Signature of Patient or Legal Representative: _____ Date: _____

Print Signers Name: _____

HIPAA Notice of Privacy Practices

Acknowledgement Form

By signing below, I acknowledge that I have been provided Premier Heart's Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information. Additionally, I have been given an opportunity to read the Notice.

Signature:_____ Date:_____

Print Name: _____

Signature of Authorized Representative: _____

Office use only:
If unable to obtain the patients signature in acknowledgment of receipt of the HIPAA Notice of Privacy Practices, document the reason below (emergency etc)

Patient Name:_____ Date:_____

Reason: _____

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE, MAY BE CHARGED on the balances owing to the provider that are past due.

Print Patient Name:	**Date:**
Patient Signature/ Legal Representative:	
Print name of Signature if different than Patient:	

Notice to all Patients:

IF YOUR MEDICAL INSURANCE REQUIRES A REFERRAL, YOU WILL NEED TO GET IN TOUCH WITH YOUR PRIMARY CARE PROVIDER TO LET THEM KNOW WHEN YOUR SCHEDULED APPOINTMENT IS AND TO ASK THEM TO ENTER A REFERRAL FOR YOU.

All office visits, diagnotic testing, or procedures scheduled at Premier Heart and all hospital testing or procedures billed by Premier Heart are subject to the following cancellation policy as follows:

Failure to notify the office in less than 48 hours prior to the scheduled appontment time will result in a bill sent directly to the patient for $50.00 per test or appointment. This is not a covered medical insurance benefit and will be payable to the office directly by the patient.

I _____, have read the office cancellation policy stated above. I understand and agree to pay $50.00 for failure to contact the office 48 hours prior to my scheduled appointment per appointment scheduled at Premier Heart's Office or at the Hospital with Dr. Kernis.

Financials:

Copays and deductibles are due at the time of your visit. We accept cash, check or credit card. All outstanding balances are to be paid in full at the time of your visit unless payment arrangements have been made with our billing department. All self-pay patients are requested to pay for their visit in full at the time of service. Failure to get necessary referrals prior to visit may result in you being responsible for the bill.

Prescription Refill Request:

Please have pharmacy request a refill electronically. You may also request through the portal or by calling the office. Please give a minimum of 72 hours' notice for a refill.

Patient Code of Conduct:

Our goal at Premier Heart is to treat every patient and their family with dignity and respect. It is our expectation that when communicating with our providers and staff our patients will be respectful and courteous. Patients who exhibit disrespectful, abusive behavior or inappropriate language will be discharged.

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Signature/ Legal Representative:_____

Date:_____

PREMIER HEART

Authorization for Release of Information

Patient Name:		**Date of Birth:**
Address:		
City:	**State:**	**Zip Code:**

I authorize the use or disclosure of the above-named individual's health information as described below.

Treatment Dates:

Rendering Facility/ Office or Disclosure Facility/Office: _____
Address: _____
_____
Phone: _____
Fax: _____

The type of information to be used or disclosed is as follows:

_____ Treatment/ visit notes	_____ EKG	_____ Reports	_____ Medication lists
_____ Lab results	_____ Radiology Reports	_____ Consult notes	_____ Other

This information may be disclosed to and used by the following individual or organization:

Premier Heart, LLC

151 Fries Mills Road, Suite 105

Turnersville, NJ 08012

Office: 856-212-0130 Fax: 856-212-0135

I understand that information in my health record may include information relating to Human Immunodeficiency virus (HIV), AIDS (Acquired Immune Deficiency Syndrome), psychological or psychiatric conditions or treatment, sexually transmitted diseases or drug/alcohol, abuse/ dependence status, detoxification or rehabilitation services. I understand that I have the right to revoke this authorization at any time. I understand if I revoked this authorization I must do so in writing and present my revocation to Premier Heart. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, this authorization will expire in 1 year. I understand that authorizing the disclosure of health information is voluntary and I can refuse to sign the form if I do not wish this request processed. I do not need to sign this form to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative: _____ Date: _____

If signed by legal representative, relationship to patient: _____