

Central Connecticut Cardiologists, LLC

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Kathleen A. Kennedy, M.D., F.A.C.C.
Steven E. Lane, M.D., F.A.C.C.
John I. Baron, M.D., F.A.C.C.

Dale T. Toce, M.D., F.A.C.C.
Atique A. Mirza, M.D., F.A.C.C.
Haris Athar, M.D., F.A.C.C.
Ann-Marie Stawarky, A.P.R.N.

PLEASE NOTE THE FOLLOWING

- If you are on any medications, please bring the actual medication bottles with you to your visit with the doctor
- If you have had any recent blood tests, EKG's, or any other tests that are pertinent to your upcoming visit, please have those reports with you on your initial appointment.
- Please complete the enclosed forms and bring them with you to your appointment. Please do not mail them back.
- Please bring your photo I.D. and insurance cards.

INSURANCE REFERRALS

Patients are responsible for obtaining any referrals from their Primary Care Physician as required by their insurance company. Failure to obtain a valid referral prior to your appointment may result in you being financially responsible for the visit at the time of service. Except in an emergency situation, the physician/office has the right to reschedule your appointment until a valid referral can be obtained. Please call the office within 24 hours to cancel the appointment.

Thank You

CENTRAL CONNECTICUT CARDIOLOGISTS, LLC
Patient Information

Patient Name:			
(Last)	(First)	(Initial)	
Street Address:			
City/State:		Zip:	
Phone Number(s)			
(Home)		(Work)	(Cellular/other)
Date of Birth:	Age:	Sex: Male / Female	Marital Status:
Social Security Number:			
Ethnicity/Race (please circle): African American American Indian or Alaska Native Asian Hispanic or Latino Native Hawaiian or Pacific Islander Caucasian			

All patients in the HMO programs are responsible for their own referrals.

Does your insurance plan require a referral? YES NO
If so, did you obtain a referral for today's visit? YES NO

Primary Care Physician: _____
Address: _____
Referring Physician (if different than above): _____
Address: _____

Primary Insurance _____ Policy # _____
Secondary Insurance _____ Policy # _____
Other Insurance _____ Policy # _____

Our office requires a copy of your insurance cards

Employer Name _____ Occupation _____
Address _____

In case of emergency please notify:

Name _____ Relationship _____

(Home Phone Number) (Work Phone Number) (Other)
Address _____

Patient/Guardian Signature _____ Date _____

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HIPAA Patient Information (Health Insurance Portability and Accountability Act)

Patient Name: _____ Date of Birth: _____

Can you be contacted by phone? Yes No

*use the following number to confirm appointments _____

Can messages be left on your answering machine? Yes No

Can phone messages be left with another person? Yes No

Can reminder notices be sent? Yes No

Can mail be sent to your home? Yes No

Authorized party to speak on your behalf:

Name	Relationship

Patient Signature: _____ Date: _____

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PAYMENT POLICY

Name of Patient: _____ D.O.B. _____

Payment is due at the time of service

Insured Patients: Your insurance policy is a contract between you and your insurance company.

We are a participating provider with many insurance plans and therefore accept assignment of benefits accordingly.

Check with your insurance provider prior to your visit to be sure your policy is one with which Central Connecticut Cardiologists participates with.

The co-payment is part of your contract with your insurer. Co-payments or deductible are your responsibility and will be collected at the time of the service.

It is the patient's responsibility to know what services are covered by their policy. If a referral is required for your visit, please make sure that information is in our office the day before your visit, or your scheduled appointment may have to be changed.

A copy of your current insurance card is required before services are rendered.

Central Connecticut Cardiologists will file your insurance claim; all charges are the patient's responsibility.

Non-Insured Patients: Payment is expected at the time of your visit. If you cannot make payment in full, a minimum deposit of \$150 is required prior to you seeing the doctor or having any tests. The \$150 is a deposit and is not the full amount that you will be responsible to pay. Payment arrangements for the balance must be made at the visit. Procedures such as cardiac catheterizations, pacemaker implants, or angioplasty/stent placement which are performed as outpatient at the hospital require a 50% deposit. These procedures will not be booked until the deposit is received. Payment arrangements for the balance must be made with the billing office before the procedure is performed. Hospital charges involved with these procedures are bill by the hospital. You can make payment arrangements with the hospital.

Payment Methods: We accept most major credit cards, personal checks, or cash.

Non-payment: If your account is 90 days past due with no payment arrangements your account will be turned over to our collection agency. While we hesitate to do this, we will pursue monies owed to the practice. If a balance remains unpaid, you will be at risk of being discharged from the practice for failure to make an honest attempt at payment. If this does occur you will receive a certified letter indicating you have 30 days to find other medical care.

If you have any questions about the above information or any uncertainty regarding the participating status with your insurance policy, please call our billing office 860-525-4005. They are here to help you.

I understand the payment policy in full and agree to the financial responsibility for myself/dependents for all medical services rendered thereof:

Signature of Patient/ Responsible Party

Today's Date

Printed Name: _____ Relationship to Patient: _____

Central Connecticut Cardiologists, LLC

NAME _____ **DATE** _____

REFERRING M.D. _____ **DATE OF BIRTH** _____ **SEX** _____

CHIEF COMPLAINT _____

Reason for consultation _____

1. Do you have now or have you ever had any of the following:

- | | | | |
|---|---|--|---|
| Yes/No
<input type="checkbox"/> <input type="checkbox"/> shortness of breath
<input type="checkbox"/> <input type="checkbox"/> asthma
<input type="checkbox"/> <input type="checkbox"/> fluid in the lungs
<input type="checkbox"/> <input type="checkbox"/> wheezing
<input type="checkbox"/> <input type="checkbox"/> emphysema
<input type="checkbox"/> <input type="checkbox"/> bronchitis
<input type="checkbox"/> <input type="checkbox"/> difficulty breathing
<input type="checkbox"/> <input type="checkbox"/> chronic cough
<input type="checkbox"/> <input type="checkbox"/> cough up blood
<input type="checkbox"/> <input type="checkbox"/> high blood pressure
<input type="checkbox"/> <input type="checkbox"/> irregular heart rate
<input type="checkbox"/> <input type="checkbox"/> rheumatic fever
<input type="checkbox"/> <input type="checkbox"/> heart murmur
<input type="checkbox"/> <input type="checkbox"/> enlarged heart
<input type="checkbox"/> <input type="checkbox"/> heart attack
<input type="checkbox"/> <input type="checkbox"/> palpitations
<input type="checkbox"/> <input type="checkbox"/> fluttering of the heart
<input type="checkbox"/> <input type="checkbox"/> chest pain
<input type="checkbox"/> <input type="checkbox"/> chest discomfort
<input type="checkbox"/> <input type="checkbox"/> cholesterol or lipid disorder
<input type="checkbox"/> <input type="checkbox"/> awakened at night by shortness of breath | Yes/No
<input type="checkbox"/> <input type="checkbox"/> change in bowel habits
<input type="checkbox"/> <input type="checkbox"/> peptic ulcer
<input type="checkbox"/> <input type="checkbox"/> constipation
<input type="checkbox"/> <input type="checkbox"/> liver disease
<input type="checkbox"/> <input type="checkbox"/> black stools
<input type="checkbox"/> <input type="checkbox"/> blood in stools
<input type="checkbox"/> <input type="checkbox"/> frequent bowel movements
<input type="checkbox"/> <input type="checkbox"/> abdominal pain
<input type="checkbox"/> <input type="checkbox"/> stroke
<input type="checkbox"/> <input type="checkbox"/> fainting spells
<input type="checkbox"/> <input type="checkbox"/> lightheadedness
<input type="checkbox"/> <input type="checkbox"/> headaches
<input type="checkbox"/> <input type="checkbox"/> slurred speech
<input type="checkbox"/> <input type="checkbox"/> weakness
<input type="checkbox"/> <input type="checkbox"/> shaking
<input type="checkbox"/> <input type="checkbox"/> visual disturbance
<input type="checkbox"/> <input type="checkbox"/> loss of vision
<input type="checkbox"/> <input type="checkbox"/> blurred vision
<input type="checkbox"/> <input type="checkbox"/> double vision | Yes/No
<input type="checkbox"/> <input type="checkbox"/> congestion
<input type="checkbox"/> <input type="checkbox"/> nose bleeds
<input type="checkbox"/> <input type="checkbox"/> excessive thirst
<input type="checkbox"/> <input type="checkbox"/> diabetes
<input type="checkbox"/> <input type="checkbox"/> thyroid
<input type="checkbox"/> <input type="checkbox"/> unusual fatigue
<input type="checkbox"/> <input type="checkbox"/> easy bruising
<input type="checkbox"/> <input type="checkbox"/> bleeding disorder
<input type="checkbox"/> <input type="checkbox"/> unexplained weight loss
<input type="checkbox"/> <input type="checkbox"/> unexplained weight gain
<input type="checkbox"/> <input type="checkbox"/> burning on urination
<input type="checkbox"/> <input type="checkbox"/> frequent urination
<input type="checkbox"/> <input type="checkbox"/> kidney problems
<input type="checkbox"/> <input type="checkbox"/> blood in urine
<input type="checkbox"/> <input type="checkbox"/> arthritis
<input type="checkbox"/> <input type="checkbox"/> pain in legs when walking
<input type="checkbox"/> <input type="checkbox"/> swelling of the ankles
<input type="checkbox"/> <input type="checkbox"/> swelling of the legs
<input type="checkbox"/> <input type="checkbox"/> varicose veins
<input type="checkbox"/> <input type="checkbox"/> muscle pain/tenderness | Yes/No
<input type="checkbox"/> <input type="checkbox"/> anxiety/panic
<input type="checkbox"/> <input type="checkbox"/> depression
<input type="checkbox"/> <input type="checkbox"/> allergies
<input type="checkbox"/> <input type="checkbox"/> drug allergies
<input type="checkbox"/> <input type="checkbox"/> adverse drug reaction

<input type="checkbox"/> <input type="checkbox"/> menstrual irregularities
<input type="checkbox"/> <input type="checkbox"/> menopause date _____ |
|---|---|--|---|

2. Medications:

Name	Dosage	Times Per day

3. Allergies:

Substance	Reaction

4. Family History:

	Age	Living	Deceased	Cause or disease
Mother				
Father				
Brother(s)				
Sister(s)				

Has anyone in your family ever had:

- Yes/No Yes/No Yes/No Yes/No
- High blood pressure Myocardial Infarction Sudden Cardiac Death Stroke
- Coronary Artery Disease Heart disease Congestive Heart Failure Diabetes

5. Smoking Status:

Tobacco History: (please circle) Current User: cigarettes cigars oral How much _____ How long _____
 Former User: cigarettes cigars oral How much _____ How long _____ When Stopped _____
 Never Smoked

6. Social History: Do you have any of the following risk factors for heart disease:

- Yes/No Yes/No Yes/No
- heart disease in family obesity sedentary life style
- stressful life style drink alcohol (Number of alcoholic drinks/week _____)
- use of unlawful drugs
- do you exercise regularly, if not why _____

Living situation/support: With whom do you live _____

7. Past History:

Surgeries

Hospital	Date	Surgery

Hospitalizations

Hospital	Date	Problem

Have you ever had

	Date	Location
Electrocardiogram		
Chest x-ray		
Angioplasty/Stent		
Exercise Test		
Exercise Test with Isotope		
Echocardiogram		
Cardiac Catheterization		
Cholesterol Test		Level
Cardiac Surgery		

8. Disability status and dates:

Physician Signature _____