Central Connecticut Cardiologists, LLC

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John I. Baron, M.D., F.A.C.C.
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Atique A. Mirza, M.D., F.A.C.C.
Haris Athar, M.D., FA.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	Yes/No	Yes/No	Yes/No
□ □ shortness of breath	□ □ change in bowel habits	□ □ congestion	□ □ anxiety/panic
□ □ asthma	□ □ peptic ulcer	□ □ nose bleeds	□ □ depression
□ □ fluid in the lungs	□ □ constipation	□ □ excessive thirst	□ □ allergies
□ □ wheezing	□ □ liver disease	□ □ diabetes	□ □ drug allergies
□ □ emphysema	□ □ black stools	□ □ thyroid	□ □ adverse drug
□ □ bronchitis	□ □ blood in stools	□ □ unusual fatigue	reaction
□ □ difficulty breathing	□ □ frequent bowel movements		
□ □ chronic cough	□ □ abdominal pain	□ □ easy bruising	□ □ menstrual
□ □ cough up blood	□ □ stroke	□ □ bleeding disorder	irregularities
□ □ high blood pressure	□ □ fainting spells	□ □ unexplained weight loss	□ □ menopause
□ □ irregular heart rate	□ □ lightheadedness	□ □ unexplained weight gain	date _____
□ □ rheumatic fever	□ □ headaches	□ □ burning on urination	
□ □ heart murmur	□ □ slurred speech	□ □ frequent urination	
□ □ enlarged heart	□ □ weakness	□ □ kidney problems	
□ □ heart attack	□ □ shaking	□ □ blood in urine	
□ □ palpitations	□ □ visual disturbance	□ □ arthritis	
□ □ fluttering of the heart	□ □ loss of vision	□ □ pain in legs when walking	
□ □ chest pain	□ □ blurred vision	□ □ swelling of the ankles	
□ □ chest discomfort	□ □ double vision	□ □ swelling of the legs	
□ □ cholesterol or lipid disorder		□ □ varicose veins	
□ □ awakened at night by shortness of breath		□ □ muscle pain/tenderness	

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_____