

Shore Cardiac Institute Office Policies

Welcome to Shore Cardiac Institute! To better serve our patients, we would like to inform you of the following policies, and provide you with important phone numbers. Please feel free to speak to the office staff if you have any further questions.

Appointments:

Office hours are by appointment only. We will attempt to remind all patients of their appointments twenty four hours prior. It is the patient's responsibility to keep their appointments; however, if you are unable to keep scheduled appointments, kindly give **24 hour notice**

Office Phone Hours: (SUBJECT TO CHANGE)

Please use the main telephone number **only**. Other numbers that may appear on your caller ID will not be answered by service when the office is closed. **The main phone number is 732-473-0158**

9:30 am-3:00pm Monday through Thursday

9:30am-12:00 noon Friday

Referrals:

Please familiarize yourself with your insurance plan.

It is the patient's responsibility to provide this office with a referral at the time of your visit if required by your insurance. If you do not have a valid referral, you will be responsible for payment in full for the visit scheduled, or you may reschedule.

Copay/Payments:

Payment/copays are due at check in on the date of visit. SCI will remind you of any outstanding balance you have and will ask that you make full payment for outstanding balances. (In extreme cases payment plans can be arranged by speaking directly to the billing office) **Billing dept phone # 732-473-1113**

Please refer to the Financial Policies for a full explanation of our Billing Policies.

Shore Cardiac Institute

Release of Records:

Shore Cardiac Institute will release patient records once all the appropriate paperwork has been completed by the patient requesting records. This office has 30 days from the date the written request has been submitted to the office to release the records. Applicable charges may be applied for any record release. Payment for records will be required at the time records are picked up. This office will only fax records when the matter is emergent and the patient is in an acute care facility.

Prescriptions:

The staff of Shore Cardiac Institute is happy to accommodate prescription refills. However, please note this office has up to 72 hours from the time the call is received to contact the appropriate pharmacy or to write a prescription for the patient to pick up. Please check your medication weekly to ensure you have enough. Since this office is closed on the weekends refills will not be available. We strongly suggest you call in your request Monday through Thursday.

Due to the problems that Shore Cardiac Institute has encountered with mail-order companies we no longer call medication directly into a mail-order company. We will give you written prescriptions for your mail order plan. Allow ample time for refills.

Laboratory Work & Testing:

Prescriptions for blood work or other testing (ultrasound, xrays...etc) are given at the time of your visit. Please have the testing done as directed. If you lose your prescription, you will have to pick up a new one at the office. We will no longer mail or fax it to you or to the testing centers. Patients who undergo monthly blood testing (PT/INR) are responsible to keep track of when their prescription expires. We will no longer be faxing prescriptions to you or the laboratory, and we will be requiring a 72 hour notice when a new prescription is needed.

Dental Procedures/Surgical Procedures

If you need to be pre-medicated or have questions/concerns about having to discontinue a medication prior to your procedure, please call our office one week prior to your scheduled date so that we can advise you appropriately.

Cardiac Clearance:

If you are scheduled for any procedure/surgery that requires cardiac clearance please be sure to contact our office as soon as possible so that we can start the clearance process. Please keep in mind that you may require testing or an appointment prior to clearance. This will ensure that you will be cleared in time for your scheduled procedure/surgery.

~~SHORE CARDIAC INSTITUTE~~

ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors are continually undergoing training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way has compromised our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak to our Compliance Officer. You have the right to review our entire notice of privacy policies upon request.

Please Sign this form to acknowledge that you have read this notice.

Patient Name: _____ Date _____

Signature: _____



SHORE CARDIAC INSTITUTE

Cardiac Catheterization-Angioplasty-Stenting-Interventional Electrophysiology
Implantable Pacemakers/Defibrillators
Nuclear Stress Testing-Echocardiography-Holter Monitoring



Date: _____

I hereby authorize you to release my records TO:

The office of Shore Cardiac Institute

Please forward my records from: (please include address and phone numbers)

I would like my:

Whole chart _____

Test Results X if so, what results All Cardiac Testing and Procedures + Lab results

Name of patient _____

Signature of patient or legal guardian _____

Address _____

Date of Birth _____ SS Number _____

Witness _____ Date _____

The protected health information you are requesting to be forwarded is considered highly confidential and will be treated as such by this practice. If it is your request to mail any records to the address above, it is your responsibility to ensure that it is protected after leaving this office.

If you are requesting this information be sent to another physician of medical facility, it is the responsibility of that facility to ensure that your protected health information is treated as such.

Shore Cardiac Institute
367 Lakehurst Road, Toms River N.J. 08755
Financial Policy

Dear Patients:

Thank you for choosing Shore Cardiac Institute. We would like to explain our billing, insurance, payment, cancelled appointment, and credit policies. We ask that you please take the time to read this financial policy thoroughly. Please sign to acknowledge that you understand and accept our terms. Please contact our billing department at 732-473-1113 to discuss any questions or concerns that you may have.

INSURANCE CARDS

Patients must present their insurance identification card(s) at EACH visit. If a patient cannot provide an I.D. card, the patient may be required to pay that day's charges in full, or reschedule the appointment.

CANCELLED APPOINTMENTS: Failure to cancel office visit appointments by 3:00 p.m. on the business day prior to the scheduled appointment will result in a \$25.00 missed appointment fee. Failure to cancel **Echo, Holter and EKG** appointments at least 24 hours prior to the appointment will result in a \$50.00 missed appointment fee. Failure to cancel **Nuclear Stress Test** appointment at least 24 hours prior to the appointment will result in a fee directly correlating to the cost of the wasted medicine dose (approximately \$134.00) as this is ordered and delivered to us for use on the date of service.

PARTICIPATING INSURANCE PROGRAMS:

We participate with many insurance programs. However, we are also required by insurance companies, including Medicare, to collect from the patient any co-insurance due and any unsatisfied deductible. As a courtesy, if you have a secondary insurance we will bill your insurance for the co-insurance and deductible.

CO-PAYS : If your insurance plan **REQUIRES** you to pay a co-pay at each visit, the payment is expected at the time of the visit. Failure to remit payment of your co-pay at your visit will force us to apply a service charge of \$10.00 for each unpaid co-payment. **Exception:** Nuclear Stress Testing

REFERRALS: If your plan requires you to have a referral for your visit to our office and each visit thereafter, it is solely **YOUR** responsibility to obtain the referral before you come to our office. You must be aware of how many visits are allowed on your referral and for the expiration date of the referral. If you do not have a valid referral for your visit, you will be responsible for all charges for that visit. **NO EXCEPTIONS.** Please keep in mind that some testing in our office is also charged to the referral.

If you have changed to a **Medicare HMO** please remember to obtain a referral from your primary care physician prior to your visit if required.

Shore Cardiac Institute

OUT OF NETWORK: If you are a policyholder with an insurance carrier that is not participating with our office, you will be required to pay for your visit at the time of service. A payment of \$50.00 must be made at the time of sign-in for office visits. We will submit your charges to your insurance carrier, and should they send us reimbursement we will gladly send you a prompt refund. If you are responsible for more than the \$50.00 paid at the office visit, you will be billed for the balance.

PAYMENT: We at Shore Cardiac Institute are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. Full payment is expected at the time of service unless other arrangements have been made in advance. This especially includes applicable deductibles and required co-payments for participating insurance companies.

Our office accepts cash, checks, Visa, MasterCard, Discover and Check Card payments for your convenience.

Any check returned to our office for insufficient funds will be re-billed with a penalty charge of \$25.00

A credit card number, expiration date, and authorized signature will be kept confidentially on file in our office. A separate form is included for this purpose.

If payment from you for past due balances due to deductible, co-insurance or services not covered by insurance or Medicare is not received by us within 60 days of the statement date we will charge the credit card on file for the balance of the account. If charging your credit card becomes necessary, a receipt will be forwarded to you promptly.

SELF PAY PATIENTS: You are required to make a payment at the time of service. An initial payment of \$150.00 must be made at the time of sign-in for office visits. This will be deducted from the amount of the actual visit and the remainder of the visit will be billed to you.

COLLECTIONS: Any charges remaining unpaid sixty (60) days after the statement date are considered past due, and will be subjected to a late fee. In this case, our billing office will make every effort to contact the person responsible for the delinquent balance, and arrange an equitable payment schedule. Further, if no effort is made to contact our business office in return and there remains a balance due for over ninety (90) days, the account will be considered seriously delinquent and will be referred to a collection agency.

If my delinquent account is sent to a collection agency, I understand that I will be charged a collection fee of \$50.00 or 20% of the balance owed, whichever is greater.

Shore Cardiac Institute
367 Lakehurst Road, Toms River, N.J. 08755

PATIENT FINANCIAL OBLIGATION AND CREDIT CARD
AGREEMENT

MC VISA DISCOVER

I, _____ hereby agree to allow Shore Cardiac Institute to bill the following named credit card for any outstanding balance not covered by my Insurance Company.

I understand that my credit card number will be treated with confidentiality in accordance with HIPPA guidelines and will not be used for any other purposes. If charging your credit card becomes necessary, a receipt will be forwarded to you promptly.

MC VISA DISCOVER

Credit Card Number

Expiration Date

Name on Credit Card

Patient Printed Name

Patient Signature

Date

Shore Cardiac Institute

Jay H. Stone, MD, FACC, FSCAI

William R. DiLorenzo, DO, FACC

Thank you for taking the time to review our office and financial policies.

Please sign below to acknowledge that you understand and accept our terms.

Patients name _____

Date of Birth _____

Responsible Party Signature _____

Print Name _____

Relationship _____

Date _____

367 Lakehurst Road, Toms River, NJ 08755 732-473-0158 – 732-473-0033 (Fax)

Shore Cardiac Institute

367 Lakehurst Road - Toms River - NJ - 08755 - 732-473-0158 (Fax) 732-473-0033

(Please Print)

Patient Name _____ Phone _____

Street Address _____ City _____

State _____ Zip _____ Email Address _____

Sex: M _____ F _____ Date of Birth _____ Age _____

Married _____ Single _____ Social Security Number _____

Primary Physician _____ Phone _____

Patient Employer _____ Occupation _____

Employer Address _____

Primary Insurance _____ ID# _____

****If insurance is under someone other than you please complete the following:****

Responsible Party: _____ Relation to patient _____

Social Security # _____ Date of Birth _____

Employer _____ Occupation _____

Secondary Insurance Name _____ ID# _____

****If insurance is under someone other than you please complete the following:****

Responsible Party: _____ Relation to patient _____

Social Security # _____ Date of Birth _____

Employer _____ Occupation _____

Assignment and Release: I, the undersigned, have insurance with _____ and assign directly to Shore Cardiac Institute or any of its doctors within the group all medical benefits, if as otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I hereby authorize any doctor to release all information necessary for my treatment or to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Signature of Insured _____ Date _____

Medicare authorization: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Shore Cardiac Institute or any of its doctors within the group services furnished to me by the physicians. I authorize any holder of medical information about me to release to the health Care Financing Administration and its agents any information needed to determine these benefits of the benefit payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA1500 form, or elsewhere other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physicians or supplier agrees to accept the allowable charge determined by the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the allowable charge determined by the Medicare carrier.

Beneficiary Signature _____ Date _____



SHORE CARDIAC INSTITUTE

JAY H. STONE, MD, FACC, FSCAI

WILLIAM R. DiLORENZO, DO, FACC

I AUTHORIZE SHORE CARDIAC INSTITUTE, PHYSICIANS AND OR STAFF TO DISCUSS MY MEDICAL CONDITION WITH THE FOLLOWING:

NAME: _____

RELATIONSHIP: _____ DATE: _____

I DO NOT AUTHORIZE SHORE CARDIAC INSTITUTE, PHYSICIANS AND OR STAFF TO DISCUSS MY MEDICAL CONDITION WITH ANYONE OTHER THAN MYSELF.

SIGNATURE: _____ DATE _____

I, _____

Do

Do Not

AUTHORIZE SHORE CARDIAC INSTITUTE, STAFF AND OR PHYSICIANS TO LEAVE MESSAGES ON MY PHONE AND OR CELL PHONE REGARDING TESTING RESULTS SCHEDULING AND ANY ISSUES RELATED TO THIS OFFICE.

PHONE NUMBER(s) _____

SIGNATURE _____ DATE _____

PRINTED NAME _____ WITNESS _____

367 LAKEHURST ROAD, TOMS RIVER, NJ 08755 732-473-0158 – 732-473-0033 (FAX)

Shore Cardiac Institute

Staff Extension Numbers

We look forward to providing you with compassionate personalized care!

It is our policy to return patient phone calls the same business day they are received. **If you do not get a return call from our office the same day please follow up with us to ensure we have your received your message.** Our phone number is 732-473-0158 and our fax number is 732-473-0033.

To better assist patients with their needs please find a list of our staff extensions below: Please dial 732-473-0158 and then press the extension number listed for assistance.

Medical Emergencies -- Extension 10

Appointments – Extension 22

Prescription refills and Lab results -- Extension 6

Nuclear Stress Test Scheduling -- Extension 24

Clinical questions for the physicians Procedure scheduling – 8

Office Manager -- Extension 8

Please leave a message and our staff will return your call!