ADVANCED CARDIOVASCULAR INTERVENTIONS, PA
6-20 Plaza Rd. Fairlawn, NJ 07410 20 Prospect Ave. Suite 809 Hackensack, NJ 07601
P:201-265-5700 *F:855-265-7385*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our Notice may change and be revised. If we change our Notice, you may obtain a copy by requesting one verbally or in writing.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

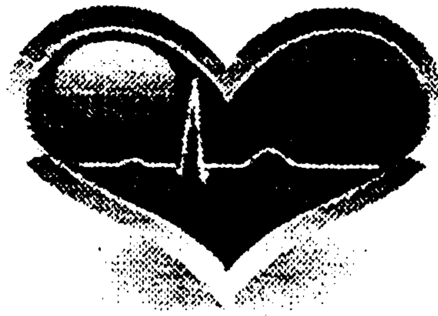
By signing this form, you acknowledge that you have received Notice of Privacy Practices.

______________________________ ______________

Name of Patient D.O.B.

______________________________ ______________

Patient's Signature Date



ADVANCED CARDIOVASCULAR INTERVENTIONS PA

Dr. Hamid M. Nia, F.A.C.C

6-20 Plaza Road

Fair Lawn NJ 07410

Phone: 201-265-5700 Fax: 855-265-7385

Assignment of Benefits Form(MEDICARE)

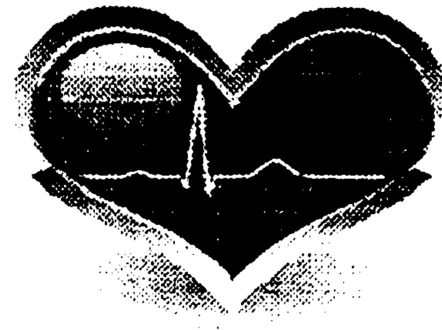
Patient:______________________________ INSURANCE ID#:____________________________________

I, ____, understand that services rendered to me by (ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA) are my financial responsibility and that the provider will bill my insurance company ______________________________, as a courtesy. I authorize my insurance company to pay my benefits directly to (ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA) and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I haves agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by (INSURANCE COMPANY).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to (ADVANCED CARDIOVASCULAR INTERVENTIONS/DR. HAMID NIA) within 48 hours. I agree that if I fail to send the payment to (PROVIDER) and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any



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check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize (PROVIDER) to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize (PROVIDER) to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated______________________________ Witness ______________________________

______________________________ ______________________________

Signature of policyholder Patient or Guardian

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Authorization to Release Your Medical Records From Our Office

Patient's Full Name: Patient's Date of Birth

Patient's Social Security Number/Medical Record Number

Address

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

ADVANCED CARDIOVASCULAR INTERVENTIONS, PA - Dr.Hamid M. Nia

2. The following person (or class of persons) may receive disclosure of protected health information about me:

His/her/its Name

Address, City, State Zip Code

3.The specific information that should be disclosed is (please give dates of service if possible):

____

____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *____________________

NO, DO NOT DISCLOSE THIS INFORMATION * ____________________

4.I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5.I may revoke this authorization by notifying ______________________________ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6.My purpose/use of the information is for ______________________________________.

7.This authorization expires on ___________, 20___, OR upon occurrence of __________________.the following event that relates to me or to the purpose of the intended use or disclosure of information about me:

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places. *

___________________________________   ____________________

Signature of patient*   Date of patient's Signature

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/ person/ facility/entity listed below.

Patient Name: ____ Date of Birth: ____________________

The information you may release subject to this signed release form is as follows:

__Complete Records
__History & Physical
__Progress Notes
__Care Plan
__Lab reports
__Radiology Reports
__Pathology Reports
__Treatment Record
__Operative Reports
__Hospital Reports
__Medication Record
__Other (Please specify below)

Release my protected health information to the following physician/ person/ facility:

Advanced Cardiovascular Interventions, PA

6-20 Plaza Rd. Fair Lawn, NJ 07410

20 Prospect Ave. Suite 809 Hackensack, NJ 07601

P: 201-265-5700 F: 855-265-7385

______________________________ ____________
Patient's Name Date

____
Patient's Signature

____
Name of Personal Representative (and description of relationship to patient)

____
Signature of Representative

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**____________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**____________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

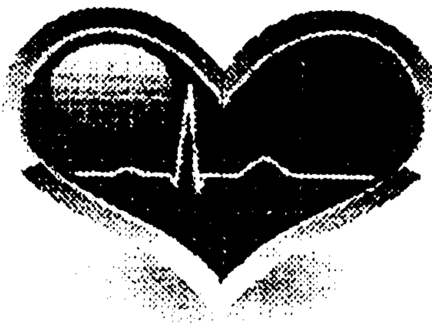
H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



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Denied Claim Patient Appeal Level One

Date: _______________

____

____

____

Patient: ________________________________

DOB: __________________________________

Member ID: _____________________________

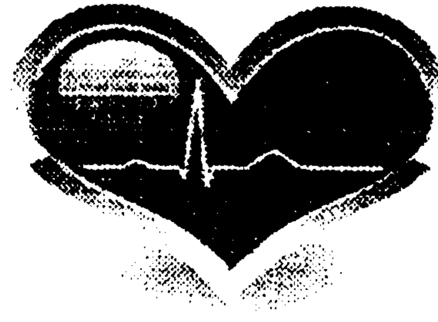
Date of Service: _________________________

To Whom It May Concern:

I have received correspondence from your company that my claim for services has been denied as not necessary. I am filing an appeal of these denied fees in expectation of eligibility and that your company will provide "good faith" administration of my benefits.

Advanced Cardiovascular Interventions, PA / Dr. Hamid Nia provides me with a comprehensive level of care and coordination of treatment warranted by my medical needs. X-rays and all necessary documentation were provided with the submitted claim. They clearly support the level of service provided.

What is your definition of "good faith"? Would you question your well-trained, licensed doctor who is personally involved with your care when evidence exists to support their treatment plan and my policy does not exclude such care?



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To you, this may be just another claim. To me, it is my medical care needs and I pay for coverage for those needs. Are you suggesting I cut corners in my medical care needs and in doing so jeopardize my health care? Is your company or reviewing professional willing to absorb any financial and legal liability for my future medical and health care needs that may be affected by your refusal of coverage? If additional information is required, please advise me promptly what specifically is required and for what purpose.

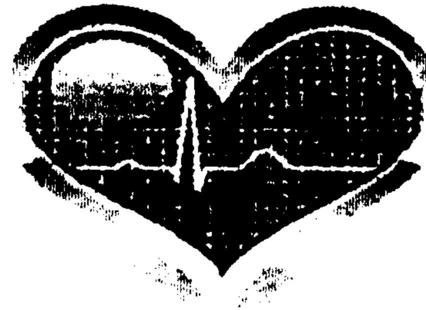
If you are prepared to deny these services, please provide me with dated and documented criteria and research that establishes your position. I am also requesting the name and credentials of the peer professional who reviewed my records and any conflict of interest in that professional who is making the determination of eligibility of services (such as, are they on your payroll?) and what they reviewed and in what format did they review it.

I am prepared to initiate a complaint process to the State or Federal agency that oversees my right to fair claims administration.

I await your reply,

____________________________ __________________

Member Signature Date



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Financial Agreement

We, the staff of **Advanced Cardiovascular Interventions, PA / Dr. Hamid Nia** thank you for choosing us as your medical provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, and in-state checks). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

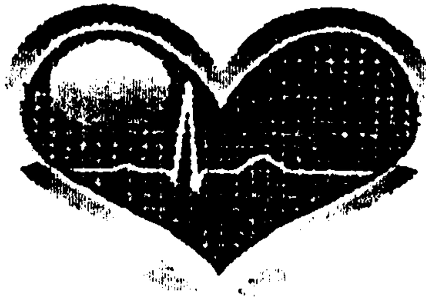
Interest

Interest will incur if a balance remains unpaid after 60 days.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of



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services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

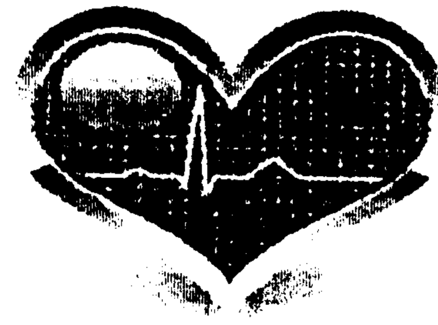
Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee may apply. These fees include $100 for a missed office visit, $50.00 per ultrasound/echo, and $250.00 for nuclear stress tests, but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.



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Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: ______________________________

Date: _______________

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Welcome to our office!

Date: ___________________

PATIENT'S NAME:		S.S#	SEX: M F	BIRTH DATE:	AGE:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:	RELIGION:	
HOME PHONE NUMBER:		CELL PHONE NUMBER:		MARITAL STATUS: S M W D SEP	
DRUG ALLERGIES, IF ANY		EMERGENCY CONTACT (Name, phone number & relationship to patient):			
ETHNICITY	PREFERRED LANGUAGE:		RACE(S):		
E- MAIL:		PHARMACY (name, town or number):			
PATIENT'S OR PARENT'S EMPLOYER:		OCCUPATION (INDICATE IF STUDENT):			HOW LONG EMPLOYED:
EMPLOYER STREET ADDRESS:		CITY AND STATE:	ZIP CODE:	BUS.PHONE # EXT. #	

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

RESPONSIBLE PARTY NAME:		RELATIONSHIP TO PATIENT:		BIRTH DATE:
*RESPONSIBLE PARTY STREET ADDRESS:	CITY AND STATE:		ZIP CODE:	HOME PHONE #:
PRIMARY INSURANCE NAME:		INSURANCE ID #:		GROUP #:
NAME OF POLICY HOLDER:		BIRTH DATE:		PLAN NAME:
INSURANCE ADDRESS:	CITY AND STATE:		ZIP CODE:	PHONE # EXT. #
SECONDARY INSURANCE NAME:		INSURANCE ID #:		GROUP #:
NAME OF POLICY HOLDER:		BIRTH DATE:		PLAN NAME:
INSURANCE ADDRESS:	CITY AND STATE:		ZIP CODE:	PHONE # EXT. #

PATIENT'S REFERRAL INFORMATION

Primary Care Physician ______________________ Phone (_____) ______________ Fax (_____) ___________

Address ___________________________ City ________________ State ______ Zip _________

Referring Physician ______________________ Phone (_____) ______________ Fax (_____) ___________

Address ___________________________ City ________________ State ______ Zip _________

Please Read and Sign this Form:

I hereby authorize my insurance benefits to be paid directly to Hamid M. Nia, M.D. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: ____ Date: _______________

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Date: ____________________

NAME: ________________________________ D.O.B.: ____________________

MEDICATION LIST:

NAME	DOSAGE	DIRECTIONS

Name: ______________________ Today's Date: ______________

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ______________________

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ______________________

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: ______________________

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ______________________

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: ______________________

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: ______________________

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ______________________

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ______________________

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ______________________

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ______________________

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ______________________

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: ______________________

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: ______________________