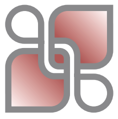

MULKAY CARDIOLOGY CONSULTANTS

HACKENSACK | UNION CITY | CLOSTER

ASSIGNMENT OF BENEFITS

Name: ______________________ Date of birth: ______________

Social Security #: ________ - ________ - ________ Date: ______________

I consent to treatment and understand that all non-covered costs, co-payments, and deductibles are my responsibility. I authorize the release of any information that was acquired during the course of my examination or treatment that may be necessary to process my medical claim. I agree to pay any charges not covered by insurance, or if I do not have insurance I agree to pay in full for the services I receive.

Patient signature: ______________________

Proxy signature: ______________________ Proxy name: ______________________

I authorize the release of any necessary medical or other information about me to the Social Security Administration and the Center for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician in order to complete a Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Patient signature: ______________________

Proxy signature: ______________________ Proxy name: ______________________

I request that payment of authorized Medigap benefits be made to either myself or on my behalf to the provider of services and/or supplier for any services furnished to me. I authorize the release of any medical information about me to:

Medigap Insurance: ______________________ HIC#: ______________________

Patient signature: ______________________

Proxy signature: ______________________ Proxy name: ______________________

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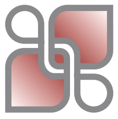
Union City, NJ 07087
T 201-601-0900 F 201-601-0995

15 Ver Valen Street
Closter, NJ 07624
T 201-996-9244 F 201-996-9243



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INSURANCE QUESTIONNAIRE

Name: ______________________________ (Nombre)

Birth Date: ______________________ (Fecha de Nacimiento)

	YES	NO
Is this visit a result of an injury at work? (Es esta visita debido a una lesion en el trabaio?)		
Is this visit a result of an accident? (Es esta visita debido a un accidente?)		
Did you or your spouse ever serve in the military? (Han presentado sus servicios al ajercito Militar de las Ustados Unidos?)		
Are you or your spouse employed? (Esta usted o su esposo empleados?)		
Are you a member of a union? (Es usted miembro(a) de una union?)		
Do you have secondary insurance or Medigap? (Tiene usted seguro secundario?)		
Have you recently made changes to your Medicare enrollment or health benefits? (Han cambiado sus beneficios medicos recientemente?)		

Signature: ______________________________ (Firma del paciente)

Date: ______________ (Fecha)

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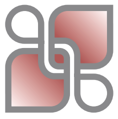

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CONSENT TO RELEASE INFORMATION

Name: ______________________ Date of birth: ______________

I authorize and give consent for Mulkay Cardiology Consultants to release my medical records and any other necessary information to my insurance company in order to process my medical claim. In addition, I authorize the billing department of Mulkay Cardiology Consultants to appeal on my behalf any denied medical claims.

Signature: ______________________ Date: ______________

CONSENTIMIENTO PARA DIVULGAR INFORMACION

Nombre: ______________________ Fecha de nacimiento: ______________

Yo par la presente autorfzo y doy mi consentimiento a divulgar mis historiales medicos y otra informaci6n relacionada a mi compania de, seguros y autorizo a apelar en mi beneficio algun reclamo(s) negado.

Firma del paciente: ______________________ Fecha: ______________

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NOTICE OF PRIVACY POLICY

Mulkay Cardiology Consultants complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Department of Health and Human Services rules that are designed to preserve privacy and identifiable patient information.

I acknowledge that I have been made aware that Mulkay Cardiology Consultants has a HIPAA policy in effect and I understand that a copy of the policy will be made available to me upon my request.

I would like to request a copy of the Notice of Privacy Practice:

______ YES ______ NO

Patient name: ______________________________ **Date:** ______________

Signature: ______________________________

If the person signing is not the patient, please print name/relationship to patient below:

Signature: ______________________________

FOR OFFICE USE ONLY:

If copy of the Privacy Policy was requested, please complete:

Date given: ____________________ **Employee:** ____________________

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