What to Bring to Your Appointment…..

- Please make sure to bring either all of your medication bottles with you or a list of the current medications you are taking.
- If you have been in the hospital, please make sure to bring the medical records with you. Our office is able to obtain the records from Morristown Medical Center.
- If you are being sent here from another physician due to abnormal testing (for example, blood work or EKG), please make sure to have a copy with you at the time of your visit.
- Please bring photo ID and your Insurance card.

These few steps will ensure safe and efficient care. Thank you.

CARDIOLOGY ASSOCIATES
OF MORRISTOWN
95 MADISON AVENUE, STE A10
MORRISTOWN, NJ 07960
PHONE: (973)889-9001 FAX: (973)889-9051

NAME: _____TODAY'S DATE_____
FIRST MIDDLE LAST
REFERRING/PRIMARY CARE DR: _____
NAME PHONE NUMBER

HOME ADDRESS: _____
CITY: _____STATE: _____ZIP: _____
TELEPHONE: ( ) _____DOB:_____AGE:_____
CELL: ( ) _____SSN#: _____
OCCUPATION: _____EMPLOYER:_____
EMPLOYER'S ADDRESS: _____
CITY: _____STATE:_____ZIP:_____
WORK PHONE: ( ) _____EMAIL: _____
RACE: _____ ETHNIC ORIGIN: _____
PRIMARY LANGUAGE:_____

NAME OF SPOUSE: _____DOB: _____
OCCUPATION: _____SSN#:_____
EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
CITY: _____STATE:_____ZIP:_____
WORK PHONE: ( ) _____CELL: ( ) _____

EMERGENCY CONTACT: _____RELATIONSHIP: _____
HOME PHONE: ( ) _____WORK/CELL#: ( ) _____

HOW DID YOU LEARN ABOUT OUR PRACTICE? _____

PRIMARY INSURANCE: _____
SECONDARY INSURANCE: _____

METHOD OF PAYMENT FOR TODAY'S VISIT: ___CASH ___CHECK __VISA/MC

OUR OFFICE WILL FILE INSURANCE FOR ALL REIMBURSABLE SERVICES, TO BOTH PRIMARY AND SECONDARY INSURANCE CARRIERS. PLEASE REMEMBER THAT YOU ARE RESPONSIBLE FOR ALL DEDUCTIBLE, COPAY, AND NON-COVERED SERVICE AMOUNTS.
SIGNATURE OF PATIET OR RESPONSIBLE PARTY_____
DATE: _____

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MORRISTOWN, NJ 07960

DAVID I. FREILICH, MD, FACC
MARK A. BLUM, MD, FACC
JOHN E. COSMI, MD, FACC

TEL: (973) 889-9001
FAX: (973) 889-9051

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM.

SIGNED: _____ (PT OR RESPONSIBLE PARTY)
DATE: _____

I AUTHORIZE PAYMENT OF MEDICAL AND SURGICAL BENEFITS TO Cardiology Associates of Morristown.

SIGNED: _____ (PT OR RESPONSIBLE PARTY)
DATE: _____

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CONSENT OF DISCLOSURE

(FOR THE USAGE AND/OR DISCLOSURE OF "PHI": PROTECTED HEALTH INFORMATION)

I HERBY GIVE CONSENT TO CARDIOLOGY ASSOCIATES OF MORRISTOWN AND ALL HEALTHCARE PROVIDERS FURNISHING CARE WITHIN CAM TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

YOU MY CANCEL THIS CONSENT AT ANY TIME. YOUR CANCELLATION MUST BE IN WRITING, SIGNED BY YOU OR ON YOUR BEHALF, AND DELIVERED TO THE ADDRESS AT THE TOP OF THIS FORM. THIS MAY BE DELIVERED IN PERSON OR BY MAIL, BUT IT WILL ONLY BE EFFECTIVE WHEN WE ACTUALLY RECEIVE IT. YOUR CANCELLATION WILL NOT BE EFFECTIVE TO THE EXTENT THAT WE OR OTHERS HAVE ACTED IN RELIANCE UPON THIS CONSENT.

YOU HAVE THE RIGHT TO REQUEST RESTRICTION ON THE USAGE AND DISCLOSURE OF YOU PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. WE ARE NOT REQUIRED TO GRANT YOUR REQUEST, HOWEVER, IF WE DO, THE RESTRICTION WILL BE OBLIGATORY TO US.

OUR POSTED PRIVACY POLICY PROVIDES MORE DETAILED INFORMATION ABOUT THE USAGE AND DISCLOSURE OF YOU PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO REVIEW OUR POSTED PRIVACY POLICY BEFORE YOU SIGN THIS CONSENT.

WE RESERVE THE RIGHT TO AMEND THE TERMS OF OUR POSTED PRIVACY POLICY. YOU MAY OBTAIN A COPY OF THE CURRENT POLICY BY CALLING OUR OFFICE AT THE NUMBER AT THE TOP OF THIS PAGE WITH A VERBAL REQUEST, OR BY COMMUNICATING YOUR REQUEST IN WRITING TO THE ADDRESS AT THE TOP OF THIS PAGE.

PLEASE COMPLETE:

- CAN OUR OFFICE STAFF LEAVE APPOINTMENT REMINDERS, CONFIRMATIONS, AND NORMAL TEST RESULTS ON YOUR ANSWERING MACHINE AT HOME **YES NO** WORK **YES NO** CELL **YES NO**
- NAMES OF RELATIVES/FRIENDS WITH WHOM WE MAY COMMUNICATE REGARDING YOUR HEALTH STATUS/INFORMATION: _____
  _____
  KINDLY NOTE: OUR STAFF WILL NOT SHARE ANY INFORMATION REGARDING YOUR HEALTH STATUS WITH ANYONE **NOT** LISTED ABOVE. IF THIS INFORMATION CHANGES, PLEASE NOTIFY OUR OFFICE.

NAME OF PATIENT: _____OR PATIENT REPRESENTATIVE: _____
SIGNATURE: _____DATE: _____
RELATIONSHIP TO PATIENT (IF NOT SELF): _____

CANCELLATION

I HERBY VOID THE CONSENT GIVEN ABOVE.

NAME OF PATIENT: _____OR PATIENT REPRESENTATIVE: _____

CARDIOLOGY ASSOCIATES of MORRISTOWN, LLC

Mark A. Blum, MD, FACC
David I. Freilich, MD, FACC
John E. Cosmi, MD, FACC

Tel (973) 889-9001 Fax (973) 889-9051
www.camorristown.com

95 Madison Avenue, Suite A-10
Morristown, New Jersey 07960
cam.cardiology@verizon.net

Name:	Allergies:
Phone:	Pharmacy:
Doctor:	Pharmacy phone #:

Medications / Amount / Dispensed / Frequency	Update Meds.	Update Meds.	Update Meds.	Update Meds.	Update Meds.	Update Meds.	Update Meds.

PATIENT AUTHORIZATION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____, authorize Cardiology Associates of Morristown to use and/or disclose my protected health information to:

_____

The protected health information that can be used and/or disclosed includes:

_____

_____

_____

The purpose of this use or disclosure is:
At my request or _____

This authorization is in effect until this date:

_____

- I understand that I have the right to revoke this authorization at any time and must do so in writing. I must present this request to the Privacy Officer at CAM or its Designated Contact Person as detailed in CAM Privacy Plan.
- I understand that the revocation will not apply to PHI that has already disclosed in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the provides my insurer with the right to contest a claim under my policy.
- I understand that any disclosure of my PHI carries with it the potential for redisclosure by the recipient and the PHI may not be protected by the federal privacy rules.

Signed: _____ Name: _____
(patient or patient representative)
Relationship to patient (if other than self) _____

PATIENT AUTHORIZATION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____, authorize _____to use and/or disclose my protected health information to:
Cardiology Associates of Morristown_____

The protected health information that can be used and/or disclosed includes:
_____
_____
_____
_____

The purpose of this use or disclosure is:
At my request or
_____

This authorization is in effect until this date:
_____

- I understand that I have the right to revoke this authorization at any time and must do so in writing. I must present this request to the Privacy Officer at CAM or its Designated Contact Person as detailed in CAM Privacy Plan.
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(patient or patient representative)
Relationship to patient (if other than self) _____