

# PETER N SAYEGH MD PC

Welcome to the office of Dr. Peter Sayegh. Please provide all insurance cards. Thank you

6/2023

Date:	Patient Last Name, First Name & Middle Initial	Date of Birth	Age	Social Security Number
Patient Mailing Address				
Town		State	Zip code:	
Patient Home Phone Number ( ) ( )	Patient Work Number ( ) ( ) Ext.	Patient Cell: ( ) ( )		
Preferred contact number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Preferred method appointment confirmation: <input type="checkbox"/> Cell <input type="checkbox"/> Email <input type="checkbox"/> Both	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		
Patient Email:				
Patient Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient is: <input type="checkbox"/> Employed <input type="checkbox"/> Retired	Occupation:		
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to answer				
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer				
Patient is: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Spouse Name:		Patient Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Name of <b>Primary</b> Insurance Carrier	Member ID Number		Group Number	
Policy Holder Name on Primary Plan	Policy Holder Birth Date	PCP Copay	PCP Selection Required? If yes, selected? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of <b>Secondary</b> Insurance Carrier	Member ID Number		Group Number	
Policy Holder Name on Secondary Plan	Policy Holder Birth Date	PCP Copay	PCP Selection Required? If yes, selected? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Care Physician		Address		
Emergency Contact		Telephone Number	Relationship	

## PETER N SAYEGH MD PC - PF-3000 (b) Notice of Privacy Practices Acknowledgement

We keep a record of the health care services provided to you. You may ask to see & copy records. You may also ask to correct records. We will not disclose your records to others unless you direct us to do so or unless the law authorizes/compels us to do so. You may see your records or get more info by contacting the administrator. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature below, I acknowledge receipt of the Notice of Privacy Practices. I authorize Peter N Sayegh MD PC and staff, and billing agent Advanced Electronic Medical Billing, Inc. to contact and send/leave voice messages, or communicate in writing regarding my medical care and insurance/billing matters. This form is effective upon execution and will remain in effect unless revoked by me.

Print Patient Name: \_\_\_\_\_ MRN Number: \_\_\_\_\_

Patient or Legally authorized individual signature X \_\_\_\_\_ Date \_\_\_\_\_ Time: \_\_\_\_\_

Printed Name if signed on behalf of Patient: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I authorize Peter N Sayegh MD PC, staff and billing agent to communicate via voice mail, U.S. Mail, and email regarding my medical care, insurance, and financial billing matters.

Patient/Guardian Signature X \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Authorization for persons/organization(s) to whom detailed information about medical care, insurance, and financial billing matters may be disclosed:

Print Name: \_\_\_\_\_ Tel: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Print Name: \_\_\_\_\_ Tel: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**PETER N SAYEGH MD PC - FINANCIAL AGREEMENT & OFFICE POLICY**

- I authorize the release of information necessary to *any and all* entities to secure the payment of benefits submitted for services rendered by Peter N Sayegh MD PC, on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service, Advanced Electronic Medical Billing, Inc., to secure the payment of benefits. I further agree that my signature on this document authorizes all claims to be submitted for benefits for all services rendered without obtaining my signature for each claim. I assign directly to Peter N Sayegh MD PC, payments for all services rendered. I also authorize Peter N Sayegh MD PC and Advanced Electronic Medical Billing, Inc., to file a complaint and insurance appeal on my behalf for any dispute or appeal regarding accurate and fair reimbursement for services rendered.
- **I understand I am financially and fully responsible for all charges if my insurance carrier denies payment for any reason.** I understand I am responsible for any deductibles, coinsurance, or copays according to my benefit plan. I understand copays and all balances on account are due at the time of visit. I understand that a delinquent balance must be paid in full prior to any scheduled appointments unless prior payment plans are made. I agree to provide Peter N Sayegh MD PC, with current insurance and provide changes within 30 days from service.
- I understand I must contact my insurance company prior to services rendered, to determine if the provider participates with my specific plan, comply with Primary Care Selection requirements, determine referral or pre-authorization needs, and understand coverage limits. I understand I am responsible for claims denied due to my failure to comply with insurance plan policy. In the event my insurance carrier issues a payment directly to me, I agree to pay Peter N Sayegh MD PC, the same amount plus any co-pays, deductibles, or coinsurances due. I agree to send in payment along with the explanation of benefits upon receipt of payment. Credit balances will remain on file and applied to future balances unless a refund is requested in writing.
- I understand that payment is due upon receipt of my monthly statement. I understand that I will be legally responsible for any and all collection and attorney fees on all balances due necessary for the collection of payment, in addition to any returned check fees.
- An appointment time has been allocated to you, and not available for other patients. We require 24 hours advance notice of all cancellations. A charge of \$30.00 will be incurred if not cancelled within 24 hours advance notice. Reminders calls are a courtesy, it is your responsibility to remember your appointment.
- Telephone prescription refills must be requested Monday-Friday between 8:30 and 4:00pm. Please allow 24-48 hours for your order to be called in. Telephone refills may be delayed due to the need for the physician to review your record. It is our belief that narcotic pain relievers are in general for short term use only. Likewise, prescriptions will not be called in after hours and on weekends.
- The clinic staff at Peter N Sayegh MD PC will return patient phone calls received before 4:00 pm Monday - Friday before the clinic closes that day. Calls received after this time will be returned the next business day. If you require urgent attention, proceed to the nearest hospital emergency room or call 911.
- Consent for treatment: I authorize Peter N Sayegh MC PC and staff to furnish any and all medical and/or surgical treatment of those mentioned, considered necessary & proper in the treatment of the patient identified below while a patient at Peter N Sayegh MD PC. This treatment may require but is not limited to, diagnostic procedures, lab testing, blood draw, testing, monitoring, and scans.

**My signature indicates my understanding & acceptance. This agreement has no term date and will remain in force until such time as a new agreement is signed.**

X

<u>Patient or Guarantor Signature (Must be 18 Years of Age)</u>	<u>Date</u>	<u>Relationship to Patient</u>
Financial guarantor name		
Financial Guarantor Date of Birth	Guarantor Social Security#	Guarantor Tel
Guarantor full address		

# CARDIOLOGY OF HUDSON VALLEY, P.C.

PETER SAYEGH, M.D.

301 N. MAIN ST. SUITE 2 NEW CITY, N.Y. 10956-4021 TEL. (845) 638-0400 FAX. (845) 638-1193

## NEW PATIENT HISTORY FORM

Today's Date:

Patient Last Name, First Name & Middle Initial	Date of Birth	Age
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Reason for today's visit:

**Answers on this form will help our health care provider better understand your medical concerns and conditions.  
If you cannot remember specific details, please provide your best guess.**

### PERSONAL MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems. Indicate with a Yes or No

Yes	No		Yes	No	
		Heart Disease: (type)			Stent Placement
		High Blood Pressure			Heart Attack
		High Cholesterol			Pacemaker Placement
		Diabetes Type 1 or Type II			Gastrointestinal Disease
		Thyroid Problem			Cancer (type): Oncologist:
		Blood Clot/DVT/Pulmonary Embolism			Back/Spinal Cord Injury
		Asthma/Lung Disease			Bypass Surgery

### PREVIOUS CARDIAC TESTINGS:

Yes	No	
		Electrocardiogram
		Echocardiogram
		Nuclear Stress Test
		Coronary Artery Calcium Scoring
		ECG Stress
		Echo Stress

### SURGICAL HISTORY:

Type of Surgery	Date of Surgery	Age at Surgery

### MEDICATIONS:

Name	Dosage	Frequency

### ALLERGIES:

Allergies:  Yes  No Type:

### FAMILY HISTORY

Please indicate yes or no, if your grandparents, parents, or brothers/sisters have had the following conditions

Yes	No		Yes	No	
		Stroke			Kidney Disease
		Stent Placement			Pacemaker Implant
		Sudden Death			High Cholesterol
		Diabetes			Blood Clots/DVT/Pulmonary Embolism
		Angina			Stroke
		Heart Attack			High Blood Pressure
		Cancer Type:			

### SOCIAL HISTORY

Cigarettes: \_\_\_\_\_ Packs/day \_\_\_\_\_ # of Years \_\_\_\_\_ Never \_\_\_\_\_ Quit

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## NEW PATIENT HISTORY FORM

Today's Date:

Alcohol Use:	Do you drink Alcohol?	Yes	No	# of drinks per week
<b>GENERAL</b>				
<input type="checkbox"/> Recent fevers/sweats <input type="checkbox"/> Change in appetite <input type="checkbox"/> Headaches		<input type="checkbox"/> Chills <input type="checkbox"/> Unexplained fatigue <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Sleeping Difficulty		
<b>SKIN</b>				
Rash		Non-healing lesions		
<b>EYES/EARS/NOSE/THROAT/MOUTH</b>				
<input type="checkbox"/> Glaucoma <input type="checkbox"/> Blurring or double vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Glasses/Contacts		<input type="checkbox"/> Ear pain <input type="checkbox"/> Hay fever <input type="checkbox"/> Allergies <input type="checkbox"/> Congestion		<input type="checkbox"/> Persistent sore throat <input type="checkbox"/> Difficulty hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Trouble swallowing
<b>RESPIRATORY</b>				
<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Obstructive Pulmonary Disease –COPD <input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Cough/wheeze <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Emphysema		
<b>CARDIOVASCULAR</b>				
<input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath with exertion <input type="checkbox"/> Heart murmur		<input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling in extremities <input type="checkbox"/> Pacemaker/Defibrillator		<input type="checkbox"/> Heart Attacks <input type="checkbox"/> Stroke <input type="checkbox"/> Valve replacement
<b>GASTROINTESTINAL</b>				
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Change in appetite <input type="checkbox"/> Nausea		<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting		
<b>GENITOURINARY</b>				
<input type="checkbox"/> Painful urination <input type="checkbox"/> Bloody urination <input type="checkbox"/> Discharge: <input type="checkbox"/> penis <input type="checkbox"/> vagina		<input type="checkbox"/> Recent urinary tract infections <input type="checkbox"/> Recent prostate infections <input type="checkbox"/> Recent kidney infections <input type="checkbox"/> Concern with sexual function		
<b>MUSCULOSKELETAL</b>				
<input type="checkbox"/> Muscle pain <input type="checkbox"/> Chronic back pain		<input type="checkbox"/> Joint pain <input type="checkbox"/> Recent back pain		
<b>NEUROLOGICAL</b>				
<input type="checkbox"/> Weakness in any part of your body <input type="checkbox"/> Recent loss of consciousness <input type="checkbox"/> Loss of energy <input type="checkbox"/> Dizzy spells		<input type="checkbox"/> Numbness in any part of your body <input type="checkbox"/> Memory loss <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Confusion		
<b>PSYCHIATRIC</b>				
<input type="checkbox"/> Anxiety <input type="checkbox"/> Stress <input type="checkbox"/> Depression		<input type="checkbox"/> Sleep problems <input type="checkbox"/> Other		
<b>ENDOCRINE</b>				
<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive hunger		<input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Thyroid problems		
<b>HEMATOLOGIC/LYMPHATIC</b>				
Anemia		Easy bruising/bleeding		Unexplained lumps
Comments:				
Patient or Guardian signature: X				Date:
Provider signature:				Date:
Date updated/Reviewed:				