Cardiology Of Hudson Valley

Peter N. Sayegh, MD
301 N. Main St., Suite 2, New City, NY 10956
P: 845-638-0400 F: 845-638-1193

Patient Acknowledgement and Agreement

At Cardiology of Hudson Valley, we are committed to providing high-quality care and timely access to appointments for all patients. Missed appointments and late cancellations limit our ability to accommodate other patients who need medical care.

Cancellation Notice Requirement

Patients are required to provide at least **24 hours' notice (1 business day)** for any appointment cancellation or rescheduling. Failure to provide adequate notice or failure to attend a scheduled appointment ("No-Show") may result in the following fees:

Appointment Type	No-Show Fee
Office Visit	**$100**
Echocardiogram	**$100**
Nuclear Stress Test	**$200**

Credit Card on File Policy

To secure scheduled appointments, patients are required to keep a valid credit card on file with the office.
If a patient fails to attend a scheduled appointment or cancels without the required notice, the applicable no-show fee may be charged to the credit card on file.

Exceptions

We understand that unexpected emergencies and unforeseen circumstances can occur. In certain situations, no-show fees may be waived at the discretion of the practice. Patients are encouraged to contact the office as soon as possible if an emergency prevents them from attending their appointment.

Patient Acknowledgment

I acknowledge that I have read and understand the No-Show & Cancellation Policy of Cardiology of Hudson Valley. I authorize the practice to **maintain** my **credit card** information securely on file and understand that applicable no-show fees may be charged in accordance with this policy.

Patient Name: _____ **Date Of Birth:** _____

Signature: _____

Date: _____

Witness/ Staff initials: _____

CARDIOLOGY OF HUDSON VALLEY

PETER N. SAYEGH, MD
BOARD CERTIFIED CARDIOVASCULAR DISEASE

301 N. MAIN ST., SUITE 2
NEW CITY, NY 10956

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Reconocimiento y Acuerdo del Paciente

En **Cardiology of Hudson Valley**, estamos comprometidos a brindar atención médica de alta calidad y acceso oportuno a citas para todos nuestros pacientes. Las citas perdidas y las cancelaciones tardías limitan nuestra capacidad de atender a otros pacientes que necesitan atención médica.

Requisito de Aviso de Cancelación
Los pacientes deben proporcionar un aviso con al menos **24 horas (1 día hábil) de anticipación** para cancelar o reprogramar cualquier cita. La falta de aviso adecuado o no asistir a una cita programada ("No-Show") puede resultar en los siguientes cargos:

Tipo de Cita	*Cargo por No Presentarse*
Visita Médica	**$100**
Ecocardiograma	**$100**
Prueba de Estrés Nuclear	**$200**

Política de Tarjeta de Crédito en Archivo
Para asegurar las citas programadas, los pacientes deben mantener una tarjeta de crédito válida en archivo con la oficina.
Si un paciente no asiste a una cita programada o cancela sin el aviso requerido, el cargo correspondiente podrá ser cobrado a la tarjeta de crédito registrada en el expediente.

Excepciones
Entendemos que pueden ocurrir emergencias inesperadas. En ciertas situaciones, los cargos por no presentarse pueden ser exonerados a discreción de la práctica médica. Se recomienda a los pacientes comunicarse con la oficina lo antes posible si una emergencia les impide asistir a su cita.

Reconocimiento del Paciente
Reconozco que he leído y entendido la Política de Cancelación y No Presentarse de **Cardiology of Hudson Valley**. Autorizo a la práctica médica a **mantener** de manera segura la información de mi tarjeta de crédito en archivo y entiendo que los cargos aplicables por no presentarse pueden ser cobrados de acuerdo con esta política.

Nombre del Paciente: _____ **Fecha de Nacimiento:** _____

Firma: _____

Fecha: _____

Iniciales del Testigo/Personal: _____

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6/2023

PETER N SAYEGH MD PC

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

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:	Preferred method appointment confirmation:	Preferred Language:
☐ Home ☐ Work ☐ Cell	☐ Cell ☐ Email ☐ Both	☐ English ☐ Spanish ☐ Other

Patient Email:

Patient Sex:	Patient is:	Occupation:
☐ Male ☐ Female	☐ Employed ☐ Retired	

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Unknown ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other ☐ Prefer not to answer

Patient is:	Spouse Name:	Patient Relationship to Insured:
☐ Single ☐ Married ☐ Widowed ☐ Other		☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Primary 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?
			☐ Yes ☐ No

Name of Secondary 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?
			☐ Yes ☐ 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 $100.00 will be incurred if not cancelled within 24 hours advance notice. Reminder 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 MD 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.

Patient Name: _____

X _____ _____ _____

Patient or Guarantor Signature (Must be 18 Years of Age) | **Date** | **Relationship to Patient**

Financial guarantor name		
Financial Guarantor Date of Birth	**Guarantor Social Securitv#**	**Guarantor Tel**
Guarantor full address		

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NEW PATIENT HISTORY FORM

Today's Date:

Patient Last Name, First Name & Middle Initial	Date of Birth	Age

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 ☐ 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	☐	☐	High Blood Pressure
☐	☐	Heart Attack			
☐	☐	Cancer Type:			

SOCIAL HISTORY

Cigarettes: Packs/day # of Years ☐ Never ☐ Former ☐ Current

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NEW PATIENT HISTORY FORM **Today's Date:** _____

Alcohol Use: Do you drink Alcohol? ☐ Yes ☐ No _____ # of drinks per week

GENERAL

☐ Recent fevers/sweats	☐ Chills
☐ Change in appetite	☐ Unexplained fatigue
☐ Headaches	☐ Unexplained weight loss
	☐ Sleeping Difficulty

SKIN

☐ Rash	☐ Non-healing lesions

EYES/EARS/NOSE/THROAT/MOUTH

☐ Glaucoma	☐ Ear pain	☐ Persistent sore throat
☐ Blurring or double vision	☐ Hay fever	☐ Difficulty hearing
☐ Cataracts	☐ Allergies	☐ Ringing in ears
☐ Glasses/Contacts	☐ Congestion	☐ Trouble swallowing

RESPIRATORY

☐ Asthma	☐ Cough/wheeze
☐ Chronic Obstructive Pulmonary Disease - COPD	☐ Coughing up blood
☐ Tuberculosis	☐ Shortness of breath
	☐ Emphysema

CARDIOVASCULAR

☐ Chest pain	☐ Palpitations	☐ Heart Attacks
☐ Shortness of breath with exertion	☐ Swelling in extremities	☐ Stroke
☐ Heart murmur	☐ Pacemaker/Defibrillator	☐ Valve replacement

GASTROINTESTINAL

☐ Abdominal pain	☐ Diarrhea
☐ Nausea	☐ Constipation
	☐ Vomiting

GENITOURINARY

☐ Painful urination	☐ Recent urinary tract infections
☐ Bloody urination	☐ Recent prostate infections
☐ Discharge: ☐ penis ☐ vagina	☐ Recent kidney infections
	☐ Concern with sexual function

MUSCULOSKELETAL

☐ Muscle pain	☐ Joint pain
☐ Chronic back pain	☐ Recent back pain

NEUROLOGICAL

☐ Weakness in any part of your body	☐ Numbness in any part of your body
☐ Recent loss of consciousness	☐ Memory loss
☐ Loss of energy	☐ Seizures or convulsions
☐ Dizzy spells	☐ Confusion

PSYCHIATRIC

☐ Anxiety	☐ Sleep problems
☐ Stress	☐ Other _____
☐ Depression	

ENDOCRINE

☐ Excessive thirst	☐ Heat intolerance
☐ Excessive hunger	☐ Thyroid problems

HEMATOLOGIC/LYMPHATIC

☐ Anemia	☐ Easy bruising/bleeding	☐ Unexplained lumps

Comments:

Patient or Guardian signature: X _____	**Date:** _____
Provider signature: _____	**Date:** _____
Date updated/Reviewed: _____	