New Patient Information

Patient Name: ________________________ Date of Birth: __________________________

Social Security Number: ___________________ Driver's license number: ____________________

Marital Status: Married Single Divorced Widowed Other Sex at birth: Male Female

Gender Identity: ________________/ prefer not to answer Preferred Language: ____________________

Home Address: ____
Street Apt Number

____
City State Zip Code

Telephone number: Home ( ) _________________ Email: _______________________________

Cell ( ) __________________ Work ( ) ____________________

Preferred method of contact for appointment reminder: Home Call Mobile Call Mobile Text Email

Emergency contact (name/relationship/phone): ____

Insurance and Prescription Information- Please give cards to front desk

Primary Insurance Company: ____________________ Subscriber social security number _________________

Subscriber Name _________________________ Subscriber date of birth _______________________

- -

Secondary Insurance Company: ____________________ Subscriber social security number _________________

Subscriber Name __________________________ Subscriber date of birth ________________________

- -

Prescription insurance company (if different from primary) ____

Contract Number______________________________ Rx Group Number___________________________

Rx Bin _______ RX Phone number for Providers (on back of your card): ______________________

Medical History Form

Most recent: Height _____________ Weight _______________ Sex at birth: Male Female

Preferred Pronouns: _____________

Medication Allergies and Reaction (use back of page if necessary):
____

Preferred Pharmacy (name/phone) ____

Family physician/PCP: ____

When was your last annual physical exam? ____

If you are taking Coumadin, who is monitoring it? ____

How were you referred to our practice? ____

Smoking history (circle): Never smoker Former light smoker Former heavy smoker Current smoker (packs per day?_______) Do you vape? Yes/ no Marijuana? Yes/ no

Alcohol History (number): __________ drinks per (day/week)? History of heavy drinking? (yes/no?)

Do you drink (fill in all that apply): Coffee (# cups per day) Tea (# cups per day)
Energy Drinks (# per day) Caffeinated soda (# cans per day)

Has anyone in your family ever had a sudden cardiac arrest? No Yes -please describe: ___________________________

Do you have a family history of heart disease, heart attacks, heart stents or coronary artery disease? No Yes
If yes, please describe age and relation: ____

Please list any major surgeries (use back of page if needed):

What Surgery?	Approximately what year?	Where was it done?

Have you had any of the following medical problems (check all that apply)?

High blood pressure		High Cholesterol		Diabetes	
Asthma/COPD		Congestive Heart failure/ CHF		Stroke	
Sleep Apnea (OSA)		Atrial fibrillation / A-fib		Prior brain bleed	
Previous Heart Attack		History of bleeding		Thyroid problems	
Previous stents or angioplasty		History of blood clots (DVT or PE/ Pulmonary embolism)		Heart bypass surgery or CABG	
Kidney disease		Cancer (if yes, what type/status)		Anemia	

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Top Cardiology Associates of Michigan

Patient Name and DOB: ____

Please fill out completely and bring to your appointment to avoid medication errors.

We will ask you to verify your med list at **every visit**. This can be done in advance via Henry Ford MyChart.

Medication	**Dose**	Route	**Frequency**	Refill Needed

HIPAA POLICY AGREEMENT

By signing below you are authorizing Top Cardiology Associates of MI to disclose information about you for:

- Ordering diagnostic tests and procedures, and calling to give you the results over the phone**.**
- Authorizing the office to release prescription information to pharmacies over the phone.
- Use of your information to fulfill standard health operations such as billing your insurance carrier(s).
- Appointment reminders via telephone, cell phone, text message and/or email based on your preference
- Authorizing the office to release medical records to other medical facilities to coordinate your care

Revocation of consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. We will request this form be updated annually. If you have any changes to your release of information policy prior to its annual renewal it will be your responsibility to notify us and complete a new form.

Reservation of Right to Change Privacy Practices: Top Cardiology Associates of MI reserves the right to modify the privacy practices. I understand that Top Cardiology Associates of MI will notify me of these changes upon my next appointment.

Signature: I have reviewed this consent form and give my permission to Top Cardiology Associates of MI to use and disclose my health information in accordance with this consent ("Notice of Privacy Policies and Practices" available upon request).

1. ____

Signature of Patient (or Legal Guardian/patient representative –please write name) Date

RELEASE OF RECORDS

- Release of records on paper must be made in person by yourself or your legal representative and will never be released on a same day basis, except in medical emergencies. You will be asked to come back and pick up records when ready.
- Release of your medical information over the phone will only be provided to the people you list below. We cannot speak to anyone on your behalf unless they are written below or you present in person to update this form. Please specify if there is any health information or conditions you wish to be excluded for the individuals listed blow.

You may release my medical records over the phone (including test results and treatment plan) to the following:

Name	Relationship	Name	Relationship

Name	Relationship	Name	Relationship

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign Top Cardiology Associates of MI any insurance or other third-party benefits available for health care services provided to me. I understand that Top Cardiology Associates of MI has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Top Cardiology Associates of MI, I agree to forward all health insurance and other third-party payments that I received for services rendered to me immediately upon receipt. I also authorize Top Cardiology Associates of MI to release any medical information requested by my insurance company to process a claim.

2. ____

Signature of Patient (or Legal Guardian) Date

PAYMENT POLICY

The information I've provided is accurate and true to the best of my knowledge. I understand that the verification of my insurance benefits is a courtesy and the estimated out-of-pocket expenses are not a written agreement or guarantee of the actual amounts that may be owed. I understand that I am responsible to pay all deductibles, co-payments, etc. according to my insurance provider for the services rendered to me. I understand that I am the final responsible party for the charges for services provided by Top Cardiology Associates of MI and I will assume total responsibility of payment in case that my insurance policy doesn't pay.

3. ____

Signature of Patient (or Legal Guardian) Date

Advance Directives

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation. Advance directives may be revoked or altered at any time by the patient. Clinicians who comply with such directives are provided legal immunity for such actions. Conversations with relatives, friends, and clinicians are most common form and should be thoroughly documented in medical record for later reference. Properly verified oral statements carry same ethical and legal weight as those recorded in writing. Other forms include instructional advance directives (such as a DNR orders, living wills).

Do you have an advance directive?

□*Yes.*

Please provide a copy to our office at your convenience. We will ensure this gets scanned to your medical records

□*No.*

Would you like a copy of the state of Michigan advanced directive form today? □*Yes.* □*No.*

A durable power of attorney for health care or health care proxy is a written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. This may include written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life- sustaining medical treatment.

Do you have a durable power of attorney?

□*Yes.*

Please provide a copy to our office at your convenience. We will ensure this gets scanned to your medical records

□*No.*

Would you like a copy of the state of Michigan advocate designation form today? □*Yes.* □*No.*

Cancellation Policy and Fee Assessment

You must call 1 business day prior to your scheduled appointment to avoid receiving a cancellation fee. Cancellation fee schedule is as listed below. This fine will be charged every time you do not give appropriate notice and for EACH appointment you failed to cancel appropriately

Nuclear Lexiscan Stress Test and Nuclear Treadmill Stress Test: **$100.**

- MEDICATION IS ORDERED SPECIFICALLY FOR YOU THE AFTERNOON PRIOR TO YOUR TEST. The medication is unable to returned. Therefore, for this test you will also be charged if your test has to be cancellation due to failure to follow the pre-procedure instruction, including eating or using caffeine/tobacco prior to the test.
- Due to the need to order the medication specifically for you, you must verbally speak to our office to confirm this test by 4:30 pm the day before the test. Failure to confirm directly with our staff will result in our office automatically cancelation of your test. No fee will be assessed in that situation.

Echocardiogram: **$50**

Carotid Duplex: **$50**

Treadmill Stress Test and: **$50**

Stress Echocardiogram: **$50**

Follow Up Appointment: **$50**

New Patient Appointment : **$50**

Loop Recorder Insertion: **$50**

I understand it is my responsibility to keep track of the appointments I schedule and if the staff is unable to reach me to remind me of my appointment that is not adequate justification for a fee waiver. I understand this fee will be charged for every appointment and every time that I do not cancel appropriately. I understand I will personally be responsible to pay these fees and they will not be billed to my insurance company.

_______________________________________ ______________

Patient signature Date

Consent to Leave Protected Health Information (PHI) on Voicemail

The HIPPA Privacy Rule permits health care providers to communicate with patients regarding their healthcare. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. The rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual's privacy, providers limit the amount of information disclosed in these messages. Messages that contain specific patient PHI require the patient to sign an authorization form to receive these messages by phone, voicemail, or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient's privacy rights under HIPPA. For example, messages that contain PHI would be the doctor's specialty, test and lab results, medication information, payment information, treatment plans, patient condition/diagnosis information, and anything else that is considered patient condition, treatment, or payment related.

You may consent to have your PHI given to you by message from the physician's office by signing this form in the space provided below. You may choose to allow the office to leave PHI messages on your home phone, cell phone or both. It is your responsibility to follow up on any messages left on your home answering machine or your personal voicemail. The office will not be responsible for relayed information which is not accessed in a timely manner by the patient. I understand my HIPPA rights and agree that Top Cardiology Associates of Michigan may leave messages for me, including those containing PHI, at the number(s) noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information

☐ Confidential messages (such as normal test results, medication information, or treatment recommendations) may be left on my **home** answering machine/ voicemail.

HOME PHONE # ____________________________

☐ Confidential messages (such as normal test results, medication information, or treatment recommendations) may be left on my **cell phone** voicemail.

CELL PHONE # ____________________________

☐ Please do NOT leave personal health information in any of my messages

____

Signature of Patient (or Legal Guardian) Date

Patient Name (printed)________________________________

TCAM

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Dr. Goswami as your healthcare provider. The office is not responsible to know the details of your specific insurance plan. The medical services you seek imply a financial responsibility on your part. This responsibility requires you to ensure payment for the services you receive.

1. You are responsible for providing us with up-to-date, accurate insurance information at the time of every appointment. In the event you knowingly provide false insurance information, you will be required to pay in full for the cost of all services rendered and be discharged from the practice.
2. If you do not have a copy of your insurance card then we will not be able to see you unless you pay in cash for the full cost of your visit at the time of check in prior to being seen by the doctor
3. It is your responsibility to contact your insurance carrier prior to your appointment to ensure Dr. Goswami is in network. If you wish to be seen "out of network" you will be responsible for any non-covered services.
4. It is your responsibility to inform us if you change your insurance between the time of your office appointment and any scheduled testing in the office. If any testing is completed without notification to the office of your change of insurance, you will be required to pay in full for all services rendered.
5. If you do not have, or choose not to use, your medical health insurance, payment in cash for the full cost of your visit is expected at time of check in prior to being seen by the doctor or any testing
6. You are responsible for knowing your insurance policy and if a referral from your primary care physician (PCP, family doctor) is required prior to being seen by a specialist. If a referral is required and not on file at time of service, you will be responsible for cash payment in full for all services received on that date or be asked to reschedule your appointment.
7. You are responsible for paying for all deductibles, co-payments, and/or co-insurance amounts and any other patient responsibility indicated by your insurance carrier. We will obtain appropriate authorizations for any tests or procedures to be completed by our office, but it is YOUR responsibility to contact your insurance carrier to determine any amount you may be required to pay prior to obtaining services at our office.
8. *In the event a check payment is returned through insufficient funds a **$25.00** check return fee will be billed to your account.*
9. The parent/guardian of a minor is responsible for payment of the minor's account balance.

Acknowledgement

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if the insurance on file denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

____________________________	____________________________	________________
Patient/ Guardian Signature	Patient Printed Name	Date

____

Witness

TCAM
Top Cardiology Associates of Michigan

The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment today.

- Please understand that payment of your bill by both your insurance company and you are required for us to stay operational and provide care.

- It is your responsibility to bring your current health insurance cards and understand exclusions in your insurance policy, and any pre-authorization or referral requirements of your insurance company. This includes understanding your deductible and your responsibility to pay what is not covered by your insurance.

- We will bill your insurance for your treatment. **It is your responsibility to provide current and accurate insurance information,** including any updates or changes in coverage. Should you fail to provide this information, **you will be financially responsible** for any balance not paid by your insurance company.

- If you do not have insurance or choose not to use your insurance then cash payment in full is expected at the time of service.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility.

____

PATIENT SIGNATURE DATE

____

PATIENT NAME (Printed)

Financial Consent for Completion of Forms

Effective Date: September 1, 2025

Patient Information

- Patient Name: _______________________________________
- Date of Birth: _______________________________________

Purpose of this Form

This document outlines our policy regarding the completion of specific administrative forms that require a physician's review, time, and signature. These forms are not considered a standard part of patient care and, therefore, are not covered by health insurance. The fees associated with these forms are for the professional time and administrative resources required to complete them accurately. Payment for these services is due at the time the request is made. **Cash or Check only**.

Fees for Form Completion

The following fees are effective as of the date above and are per form/request:

- VA Forms: $20.00
- Disability Forms: $20.00
- FMLA Forms: $20.00
- Disability Parking Pass: $10.00
- Unlisted Forms: $10.00- $20.00
    - Price range based on complexity/time to complete forms.

Patient Agreement

I, the undersigned, acknowledge and agree to the following:

1. I have read and fully understand the fee schedule for the completion of administrative forms.
2. I understand that these fees are for professional and administrative services and are my sole financial responsibility.
3. I agree to pay the specified fee at the time I submit a request for any of the forms listed above.
4. I understand that the completion of these forms is contingent upon the physician's professional opinion and a thorough review of my medical record. The physician is not obligated to complete a form if it is inconsistent with the medical record. I understand my forms will not be completed until payment is received.
5. I understand money will be returned/refunded if the office is unable to complete forms.

Patient/Legally Responsible Party Signature: ____

Printed Name (if not patient): ____

Date: ___________________