Ocean Cardiovascular Specialists

Murat Karatepe, MD, FACC
Asu Rustemli, MD, FACC
Cardiac Catheterization – Echocardiogram – Carotid Sonogram – Nuclear Stress Testing

Thank you for scheduling with us! Here is a check list of documents that could help make your first appointment go smoother.

Plan to arrive 15 min early with your completed forms! Late arrivals may have to be rescheduled.

Please be sure to bring (or have faxed to us at 732-505-9919), the following:

- Photo ID
- Insurance Cards
- latest EKG
- latest lab results
- a complete list of ALL medications that you are taking
- and any prior cardiac testing (if applicable)
- any advanced directive that you may have

Please note - We do NOT participate in NJ Family Care, Amerigroup/Wellpoint, United Healthcare Community Plan, Horizon NJ Health, Fidelis Care, Aetna Better Health or Medicaid even if you have another insurance. Failure to disclose this information when registering will result in discharge from the practice.

We ask for your consideration by kindly giving us 24 hours' notice if you need to cancel or reschedule your New Patient Appointment please*!*

If your appointment is for MEDICAL CLEARANCE, PLEASE bring a script or referral from your doctor that details the date of your surgery, the type of surgery, the type of anesthesia as well as any pre-admission testing that was done prior to your visit.

Sincerely,

Ocean Cardiovascular, LLC

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Date: _____

Patient Name: _____ DOB: _____ M/F _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

E-mail: _____ Social Security #: _____

Contact Preference: Home phone: ____ Cell Phone: ____ Opt in for Text Messaging? [ ] Yes [ ] No

Employer: _____ Employer phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Race: _____ Ethnicity: _____ Primary Doctor: _____ Referring Doctor: _____

Contact Information
Emergency Contact: _____ Phone: _____
Relation: _____

Emergency Contact: _____ Phone: _____
Relation: _____

Pharmacy Information:

Local pharmacy: _____ Road: _____ City: _____

Phone: _____ Fax: _____

Mail order: _____

Insurance Information:

Primary insurance: _____ Member ID: _____

Subscriber name: _____ DOB: _____

Secondary insurance: _____ Member ID: _____

Subscriber name: _____ DOB: _____

Person with financial responsibility for this account: _____

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FINANCIAL POLICY (updated 2026)

Financial Responsibility
Payment is expected at the time services are rendered unless prior arrangements have been made. Patients are responsible for all charges incurred, including copayments, coinsurance, deductibles, non-covered services, and charges denied by insurance. Providing insurance information does not eliminate financial responsibility. Insurance coverage is a contract between the patient and the insurance carrier, and the patient remains responsible for any balance not paid by insurance.

Assignment of Benefits & Authorization
I authorize payment of medical benefits directly to **Ocean Cardiovascular** or any physician within the group. I authorize the release of medical information necessary for treatment, insurance processing, and securing payment. I understand that I am financially responsible for all charges, regardless of insurance payment.

Medicare Authorization (If Applicable)
I request payment of authorized Medicare benefits to be made directly to Ocean Cardiovascular Specialists. I authorize the release of medical information necessary to determine and process Medicare benefits. I understand that I am responsible for applicable deductibles, coinsurance, and non-covered services.

Billing & Statements
Statements are provided as a courtesy. Failure to receive a statement does not excuse payment responsibility. Balances are expected to be paid within a reasonable time.

Payment Plans
Patients experiencing financial hardship may request an authorized payment plan, which must be approved by the practice and followed exactly as agreed. Missed or late payments may result in termination of the plan and will be considered non-payment.

Inactive Accounts & Appointment Policy
Any account with an outstanding balance that remains unpaid for **six (6) months**, and does not have an active, authorized payment plan in place, will be designated as **inactive**.
Inactive accounts will not be permitted to schedule future appointments, and existing appointments may be canceled. Non-urgent care may be suspended. Emergency medical care will not be denied, as required by law. Appointment privileges may be restored once the balance is paid in full or an authorized payment plan is established and maintained.

Collections
Unpaid balances may be referred to a collection agency. Patients may be responsible for reasonable collection costs as permitted by law.

Returned Payments
Returned checks, declined cards, or rejected electronic payments may result in additional fees and require future payments to be made by certified funds.

Policy Changes
Ocean Cardiovascular reserves the right to modify this Financial Policy at any time.

Acknowledgment
I acknowledge that I have read, understand, and agree to this Financial Policy.

Printed Name: _____
Signature: _____Date: _____

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Date: _____

Patient name: _____

☐ I hereby authorize ***Ocean Cardiovascular Specialists*** and its physicians and or staff to leave messages for me at home regarding test results, scheduling of appointments and other issues related to this medical office

☐ I hereby authorize ***Ocean Cardiovascular Specialists*** and its physicians and or staff to discuss my medical condition with:

Name: _____ Phone: _____

Relation: _____

Name: _____ Phone: _____

Relation: _____

☐ I DO NOT authorize ***Ocean Cardiovascular Specialists*** and its physicians and or staff to discuss my medical condition with anyone other than myself

Patient signature: _____ Date: _____

Witness: _____

25 Mule Road, Suite B1-3 | Toms River, NJ 08755 | Tel: 732-505-9005 | Fax: 732-505-9919

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Date: _____

Patient name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____

Dear, _____;

I hereby authorize the release of my medical records (hospital procedures, testing, office notes, lab results, ect.) to ***Ocean Cardiovascular Specialists*** – Dr. Murat Karatepe and or Dr Asu Rustemli.

Please forward my record **via fax** to:

25 Mule Road, Suite B1-3 | Toms River, NJ 08755 | Tel: 732-505-9005 **| Fax: 732-505-9919**

Printed name: _____

Signature of patient: _____ Date: _____

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Telehealth Consent Form

Patient Name: _____ Date: _____

The purpose of telemedicine is for a patient and a medical provider, who are at two different locations, to have a medical visit. Through the use of technology, the patient and provider can see and hear each other and have a conversation as if they were in the same room. It is also possible for the provider to conduct a limited physical examination, either by asking the patient, or another health professional who is with the patient, to assist. Telemedicine visits may be scheduled speaking to a staff member from the registration department (by phone or in person) and requesting a telemedicine visit. The health center bills for telemedicine visits using the same processes and amounts as an in-person visit. The benefit of telemedicine is that a patient can receive medical attention without needing to travel and often that means getting the care needed more quickly. In the event of equipment or software failure, the provider will call the patient and either make arrangements for an in-person visit or reschedule the telemedicine visit.

Provider responsibilities:

1. Sit in a private location in which no one can overhear the conversation.
2. Review the patient's medical record before beginning the visit.
3. Use technology that is secure (cannot be intercepted electronically).
4. Document a thorough note in the medical record after the visit.
5. Ask permission from the patient if anyone else will be in the room.
6. To NOT record the visit.
7. To stop the visit if the patient does not want to continue.
8. Maintain the confidentiality of patient information.

Patient responsibilities:

1. Cancel telemedicine visits that you cannot attend at least 24 hours in advance. Be on time for your visit.
2. Sit in a private location in which no one else can overhear the conversation.
3. Turn off other electronic equipment (TV, radio) so that you can fully participate in the visit.
4. Let the provider know if someone else is in the room with you.
5. Make sure that the provider has your correct phone number in case the provider needs to call.

Patient rights:

1. To decline having a visit done with telemedicine or stop a visit that has started.
2. To file a formal complaint regarding any problem that occurred during a telemedicine visit. Please call the main number 732- 505-9005 and ask to file a complaint.

I have read (or had read to me) the above information about telemedicine including the purpose of telemedicine, provider and patient responsibilities, my rights, how to file a complaint and what to do if the equipment fails and I agree to participate in telemedicine visits. I may withdraw this consent at any time. A copy of this consent will be filed in my medical record.

Signature: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

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Prescription Medication	Dosage (mg)	Times per day	Form (tablet, capsule, liquid)	Special Instructions

Name: _____ DOB: _____

Primary care Physician: _____ Pharmacy Name: _____

Phone: _____ Phone: _____

Address: _____ Address _____

Drug Allergies:

25 Mule Road, Suite B1-3 | Toms River, NJ 08755 | Tel: 732-505-9005 | Fax: 732-505-9919