TEXAS VASCULAR ASSOCIATES, PA

Patient Information

General Information: Today's Date: ______________________________

____ Mr. ____ Mrs. ____ Ms. ____ Dr. Marital Status: **Circle One**: Single Married Divorced Widow

Gender: ___ Male ____ Female Age: ________ Treating Physician: ______________________________

Patient Name: ____
Last First Middle (Preferred Name/Nickname)

Home Address: ____
Street Name City State Zip Code (County)

Date of Birth: ______________________________ Social Security #: ______________________________

Email Address: ______________________________ Cell Phone #: ______________________________

Home Phone #: ______________________________ Work Phone # & Ext.: ______________________________

Driver's License #: ____________________ Exp: ______ Secured Fax Number: ______________________________

Employer Name: ______________________________ Occupation: ______________________________

Language(s) Spoken: ______________________________ Religion: ______________________________

Ethnicity: Circle one: Hispanic or Latino Not of Hispanic Origin Patient Declined

Race: Circle one: White/Caucasian Black/African American Asian American Indian/Alaskan Native Refused to report

Preferred Communication: Cell Phone Home Phone Work Phone Encrypted Email Message Secured Fax

Name of Referring Physician: ______________________________ Telephone #: ______________________________

Name of Primary Care Physician: ______________________________ Telephone #: ______________________________

How did you hear about us: Circle one: Referral Insurance Directory Family/Relative Newspaper Internet Phone Directory

EMERGENCY CONTACT INFORMATION:

(1) Name: ______________________________ Relationship: ______________________________

Telephone Number (s): ____

(2) Name: ______________________________ Relationship: ______________________________

Telephone Number (s): ____

If the patient lives in a nursing home, please provide the name, address and telephone number of the facility:

Name of Facility: ____

Address: ____

Facility Phone #: ______________________________ Contact Name: ______________________________

Patient Name: ______________________ Date of Birth: ______________

BILLING INFORMATION (If different from patient):

Name of Person Financially Responsible for Account: ______________________

Relationship to Patient: ______________ SSN: ______________ DOB: ______________

Home #: ______________ Cell #: ______________ Work #: ______________

Address: ______________________

GUARDIAN INFORMATION: (Please complete this portion if patient is a minor (under 18 years of age)

Mother's Name: ______________ Father's Name: ______________

Address: ______________ Address: ______________

Tel #: ______________ Tel #: ______________

Employer: ______________ Employer: ______________

Work #: ______________ Work #: ______________

HEALTH INSURANCE INFORMATION:

Name of Primary Insurance: ______________________

Policy #: ______________ Group #: ______________ Plan#: ________ Effective Date: ______________

Name of Policy Holder: ______________________ Relationship to Patient: ______________

Policyholder's Date of Birth: ______________________ Social Security Number: ______________

Name of Secondary Insurance: ______________________

Policy #: ______________ Group #: ______________ Plan#: ________ Effective Date: ______________

Name of Policy Holder: ______________________ Relationship to Patient: ______________

Policyholder's Date of Birth: ______________________ Social Security Number: ______________

Name of Tertiary Insurance: ______________________

Policy #: ______________ Group #: ______________ Plan#: ________ Effective Date: ______________

Name of Policy Holder: ______________________ Relationship to Patient: ______________

Policyholder's Date of Birth: ______________________ Social Security Number: ______________

Patient Name: ______________________________ Date of Birth: ____________________

CONDITIONS OF REGISTRATION AND FINANCIAL POLICY

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

- **PAYMENT POLICY –** Payment is due in full at the time service is provided in our office.
- **FOR PATIENTS WITH MEDICARE –** We will bill Medicare on your behalf. As a courtesy, we will also bill secondary and tertiary insurance carriers on your behalf. You are responsible for all copays, deductibles, coinsurances, supplies and non-covered services.
- **FOR PATIENTS WITH INSURANCE –** All copays, deductibles and coinsurances are due at the time of service. Please be advised that your arrangements with your insurance carrier(s) are private and ultimately – you are responsible for payment.
- **NON-COVERED SERVICES –** Any care not paid for by your existing insurance coverage will require payment in full at the time of services are provided or immediately upon notice of insurance claim denial.
- **MISSED APPOINTMENTS –** In fairness to other patients and our doctors, we require at least 24 hour notice to cancel an appointment.
- **RETURNED CHECKS –** There will be a fee of $25.00 charged by this office for each check returned to us by your bank.

Patient Initials Here ________

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the vascular surgeons of Texas Vascular Associates, P.A., to furnish my insurance company(ies), attorney or legal representative(s) all information in which said parties may request concerning my present illness or injury. I hereby assign the above-named physicians all monies/benefits to which I am entitled for medical and/or surgical expenses relative to the service reported herein, but no to exceed my indebtedness to said physicians and surgeons. I appoint Texas Vascular Associates, P.A. to act as my authorized representative regarding my insurance, and I agree that if my claim is denied, I request that an appeal be filed. If the payment denial is overturned in appeal, I agree that the plan's payment should be paid directly to my authorized representative and direct the plan to do so in that event. I consent to and authorize the physicians at Texas Vascular Associates, P.A. to treat any conditions that I might have and seek treatment for. Please be advised that certain physician owners of Texas Vascular Associates, P.A. have an indirect ownership interest in the Baylor Jack and Jane Hamilton Heart and Vascular Hospital and Texas Heart Hospital of Plano (the "Hospitals). Due to such ownership interest, your treating physician may receive, indirectly, remuneration as a result of procedures performed at these Hospitals. If you do not wish to be admitted to either of these Hospitals, you may choose another hospital at which your physician is credentialed to perform professional medical services and procedures. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Initials Here __________

MEDICARE PATIENTS: SIGNATURE ON FILE:

I request and authorize payments of Medicare benefits be made to Texas Vascular Associates, P.A., for any services furnished to me by the provider. I authorize any holder or medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of information necessary to adjudicate the claim. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible and coinsurance, and any non-covered services.

Patient Initials Here __________

I have read, understood, and agrees to be bound by the terms of this financial policy.

____ ______________________________

Signature of Patient or Patient Representative **Date** **Relationship of Patient Representative to Patient**

Patient Name: ______________________________ Date of Birth: ____________________

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Texas Vascular Associates, PA Notice or Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my Protected Health Information (PHI), Texas Vascular Associates PA must have my consent. Therefore, I authorize Texas Vascular Associates PA to disclose my Protected Health Information (PHI) as described on this form, to the recipients listed below: Description of the information to be disclosed (Check all that applies):

___ All Procedures ___ Sonograms/Radiology Results ___ Lab Results ___ Medical Treatments Notes

___ Others: ____

Please list the individuals who may access your protected health information (PHI):

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

OR

________ I DO NOT authorize Texas Vascular Associates PA to release my Protected Health Information (PHI) to anyone other than myself. I fully understand that by doing so that it may take longer to get my results.

Contact Information

I authorize Texas Vascular Associates PA to contact me at the following numbers with results or questions:

Home #: ____________________ Cell #: ____________________ Work #: ____________________

May we leave results on your answering machine or voicemail? Circle one: YES NO

May we send you encrypted message regarding your results via email? Circle one: YES NO

Provide your email address: ____

May we leave appointment messages on your voice mail, answer machine or individual answering your calls? Circle one: YES NO

I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. Furthermore, I understand that this consent can be revoked at any time except to the extent that disclosure in good faith has already occurred in reliance to this consent. This agreement shall remain in effect for 365 days from date signed.

____ ______________________________

Patient or Representative Signature: Date Signed:

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ______________________________

MEDICAL HISTORY CONSENT FORM

By signing below, I give permission to Texas Vascular Associates, P.A. to access my pharmacy benefits data electronically. This consent will enable Texas Vascular Associates, P.A. to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers.

Patient/Representative Signature & Date Signed: ______________________________ Relationship: ____________________

Witness Signature: ______________________________________ Date: ______________________

<table>
<tr><td>Pharmacy Name:</td><td>Telephone Number:</td></tr>
<tr><td colspan="2">Address:</td></tr>
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<tr><td>Pharmacy Name:</td><td>Telephone Number:</td></tr>
<tr><td colspan="2">Address:</td></tr>
</table>

PATIENT NAME: ________________________ DATE OF BIRTH: ____________________

PATIENT PHYSICIANS LIST

PLEASE LIST BELOW ALL THE DOCTORS YOU SEE ON A REGULAR BASIS:

(Example: Primary Care, Cardiologist, Nephrologist, Urologist, Obstetric/Gynecologist, etc.)

Doctor: ____________________ (First and Last Name) Specialty: ____________________ Address: ____________________ City, State, Zip: ____________________ Telephone #: ____________________ Fax #: ____________________	Doctor: ____________________ (First and Last Name) Specialty: ____________________ Address: ____________________ City, State, Zip: ____________________ Telephone #: ____________________ Fax #: ____________________
Doctor: ____________________ (First and Last Name) Specialty: ____________________ Address: ____________________ City, State, Zip: ____________________ Telephone #: ____________________ Fax #: ____________________	Doctor: ____________________ (First and Last Name) Specialty: ____________________ Address: ____________________ City, State, Zip: ____________________ Telephone #: ____________________ Fax #: ____________________
Doctor: ____________________ (First and Last Name) Specialty: ____________________ Address: ____________________ City, State, Zip: ____________________ Telephone #: ____________________ Fax #: ____________________	Doctor: ____________________ (First and Last Name) Specialty: ____________________ Address: ____________________ City, State, Zip: ____________________ Telephone #: ____________________ Fax #: ____________________
Doctor: ____________________ (First and Last Name) Specialty: ____________________ Address: ____________________ City, State, Zip: ____________________ Telephone #: ____________________ Fax #: ____________________	Doctor: ____________________ (First and Last Name) Specialty: ____________________ Address: ____________________ City, State, Zip: ____________________ Telephone #: ____________________ Fax #: ____________________

TEXAS VASCULAR ASSOCIATES, P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

EFFECTIVE 9-1-2013

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Texas Vascular Associates, PA, including its providers and employees (the "*Practice*").

I. <u>OUR OBLIGATIONS</u>.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. <u>HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU</u>.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. **<u>For Treatment</u>.** We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. **<u>For Payment</u>.** We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. **<u>For Health Care Operations</u>.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. **<u>Quality Assurance</u>.** We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. **<u>Utilization Review</u>.** We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. **Credentialing and Peer Review.** We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

H. **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

I. **Appointment Reminders and Health Related Benefits and Services**. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine, sending encrypted email, reminder cards, paper mail or secure faxes) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

J. **Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

K. **Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

L. **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

M. **To Avert an Imminent Threat of Injury to Health or Safety.** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

N. **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

O. **Research.** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

P. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

Q. **Workers' Compensation.** We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

R. **Public Health Risks.** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

S. **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

T. **Legal Matters.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

U. **Law Enforcement, National Security and Intelligence Activities.** In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

V. **Coroners, Medical Examiners and Funeral Home Directors.** We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

W. **Inmates.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

X. **Marketing of Related Health Services.** We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

Y. **Fundraising.** We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Z. **Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. **Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. **Psychotherapy Notes, Marketing and Sale of Medical Information.** Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. **Right to Revoke Authorization**. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. **Right to Inspect and Copy.** Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. **Right to Amend.** If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. **Right to Breach Notification.** In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

TEXAS VASCULAR ASSOCIATES, P.A.
Attn: HIPAA Officer
621 N. Hall Street, Suite #100 Dallas, Texas 75226
Tel #: (972) 764-8541

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

____

____

____

Patient Name: ____

(Please Print Name)

Patient Date of Birth: ____

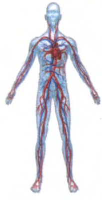
SIGNATURES:

Patient/Legal Representative: ______________________________ Date: ____________________

If Legal Representative, relationship to Patient: ____

Witness (optional) : ______________________________ Date: ____________________

U:Notice of Privacy Practices/NPP Revised as of 7-8-2014.docx



TEXAS VASCULAR ASSOCIATES, PA

Vascular Diagnosis
Vascular Surgery
Endovascular Therapy
Vascular Medicine
Arterial & Venous Disorders

Bertram L. Smith, M.D., F.A.C.S.*
Gregory J. Pearl, M.D., F.A.C.S.*
William P. Shutze, M.D., F.A.C.S.*
Dennis R. Gable, M.D., R.V.T., F.A.C.S.*

Brad R. Grimsley, M.D., F.A.C.S.*
Stephen E. Hohmann, M.D., F.A.C.S.*
John C. Kedora, M.D., R.P.V.I, F.A.C.S.*
John F. Eidt, M.D., F.A.C.S.*

Ashley Moore, RN, ACNP-BC
Kate Murphy, MS, FNP-C

* Board Certified in Vascular Surgery

Texas Vascular Associates, PA
Payment Policy

The staff and physicians of Texas Vascular Associates, PA wish to extend you a warm welcome to our practice for your comprehensive vascular care. Our office strives to provide you the best quality care that can be offered. We hope to establish and maintain good communication with you, your other medical providers and our staff.

Due to recent changes in health care laws and insurance coverage options, our office is required to implement new policy guidelines for deductibles and any balance that is accrued while under the care of our physicians and staff. We hope that with this communication, our office and staff provide you plenty of time prior to your initial and any subsequent visits (or procedures) that are scheduled so that you can be prepared to make payments **as are required**. As always and when appropriate, initial submission for insurance coverage will continue to be done prior to requesting further payment from you as our patient but this does not apply to any deductible that is determined to be your responsibility.

Payment deemed to be your responsibility is expected at the time services are rendered. Any balance resulting from office services/visits that are deemed to be your responsibility are expected and will be collected at the end of each office visit. Additionally any balance that is accrued from prior procedures performed that are deemed to be your responsibility must be resolved and paid as necessary no later than the next office visit. All balances owed up to $1000 must be paid in full. If the balance owed is greater than $1000, a minimum of 30% of the balance must be made no later than the next office visit. Our office will certainly try our best to set up a payment plan for payments on a monthly basis for balances over $1000 but will not be able to implement any payment plan that goes beyond 24 months. Additionally, if any monthly payment that is set up is not made in a timely manner, the entire balance will be due immediately and no further services will be able to be provided until the payment is complete.

If payments are not made in a timely manner, unfortunately our office will have no option other than to forward information to a collection agency for further action. Texas Vascular Associates, PA apologizes for any inconvenience this may cause. We appreciate your understanding

Cordially,
Texas Vascular Associates, PA

Patient name (printed) ________________________________ DOB ________________

Signature ____ Date ________________

621 N. Hall Street, Suite 100, Dallas, TX 75226, (214) 821-9600, Fax: (214) 823-5290

399 W. Campbell Rd., Suite 300, Richardson, TX 75080, (972) 665-9100, Fax: (972) 665-4711

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