VILLAGE Heart & VEIN CENTER

8575 NE 138Th Lane
Lady Lake, Fl 32159

Phone (352) 674-2080
Fax (352) 674-2178

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND RELEASED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Will Follow This Notice:

This notice describes our practice's privacy practices and that of:

- Any physician or health care professional authorized to enter information into your medical chart.
- All areas of the practice
- All employees, staff, and other office personnel
- All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other or with third party medical specialists for treatment, payment, or office operations purposes described in this notice

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our medical office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office.

This notice will tell you about the ways in which we may use and release medical information about you. We also describe your rights and certain obligations we have regarding the use and release of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of this notice that is currently in effect

How We May Use and Release Medical Information About You:

The following categories describe different ways that we use and disclose medical information. Not every use or release category will be listed. However, all of the ways we are permitted to use and release information will fall within one of the categories.

- **For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may release medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may release medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have consented to such release. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.
- **For Payment:** We may use and release medical information about you so that the treatment and services you receive at the medical office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about medical procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

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- **For Health Care Operations:** We may use and release medical information about you for medical office operations. These uses and releases are necessary to run the medical office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many medical office patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also release information to physicians, nurses, and other office personnel for review and learning purposes.
- **Appointment Reminders:** We may use and release medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office.
- **Treatment Alternatives:** We may use and release medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services:** We may use and release medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved In Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such release. We may also give information to someone who helps pay for your care. In addition, we may release medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required By Law:** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety:** We may use and release medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any release, however, would only be to someone able to prevent the threat.

Special Situations:

- **Health Oversight Activities:** We may release medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may release medical information about you in response to a court or administrative order. We may also release medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Coroners, Medical Examiners and Funeral Directors:** We may also release 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 patients of the office to funeral directors as necessary to carry out their duties.

Your Rights Regarding Medical Information About You:

You have the following rights regarding medical information we maintain about you:

- Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our office manager. If you request a copy of the information, there will be a fee for the costs of copying, mailing, or other office supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances.

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- Right to Amend: If you feel that 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 or for the medical office. To request an amendment, your request must be made in writing and submitted to the office manager. In addition, you must provide a reason that supports your request. 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:

  1. Was not created by us, unless the person or entity that created the
  2. information is no longer available to make the amendment;
  3. Is not part of the medical information kept by or for the medical office;
  4. Is not part of the information which you would be permitted to inspect and copy; or
  5. Is accurate and complete
- Right to an Accounting of Disclosures: You have the right to request an "accounting of Disclosures." This is a list of the releases we made of medical information about you.

To request this list of disclosures, you must submit your request in writing to our medical records department. Your request must state a time period which may not be longer than six years and may not include dates before 4-13-03. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost 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.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or release about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we release about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or release information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our office. In your request, you must tell us

(1) what information you want to limit;
(2) whether you want to limit our use, release or both; and
(3) to whom you want the limits to apply, for example, releases to your spouse.

- 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 work or by mail. To request confidential communications, you must make your request in writing to the office manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- 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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, you may request a copy from our front office staff.

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Changes To This Notice:

We reserve the right to change this notice. 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 the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top left hand corner, the effective date. In addition, each time you register we will offer you a copy of the current notice in effect.

Complaints:

If you believe you privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our practice manager. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

Other Uses Of Medical Information:

Other uses and releases of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or release medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or release medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any release we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

If you have any questions about this notice, please contact the practice manager.

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Notice of privacy practice acknowledgement form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment or healthcare operations as described in our Notice. You have the right to revoke this consent in writing, except we have already made releases in reliance on your prior consent.

Patient Signature: _____

Patient Name: _____

Date: _____

Witness: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Last Four digits SS _____

I request and authorize the following health care providers to release healthcare information of the patient named above

Provider Name_____ PH_____ FX_____

Provider Name_____ PH_____ FX_____

Provider Name_____ PH_____ FX_____

Name: Village Heart and Vein

Address: 8575 NE 138th Lane

Lady Lake Fl 32159

☐ Healthcare information relating to Cardiology , EP or Peripheral Disease

☐ Last Progress note and all Cardiac testing

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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Patient Information Sheet

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ St _____ Zip _____

Contact Number _____ Cell Number _____ Work Number _____

Primary Care Physician _____ Referring Physician _____

Date of Birth _____ Male ____ Female ____ Marital Status:(Circle) Married, Single

SS# _____ Employer Name _____

Insurance Company _____ Phone Number _____

Subscriber # _____ Group # _____

Copay _____ Deductible _____ Coverage% _____

Policy Holders Name Party (if not self)

Last Name _____ First Name _____ Mi _____

Street Address _____ City _____ St _____ Zip _____

Date of Birth _____ SS# _____ Relation _____

Secondary Insurance

Insurance Company _____ Phone Number _____

Subscriber # _____ Group # _____

Copay _____ Deductible _____ Coverage% _____

Policy Holders Name Party (if not self)

Last Name _____ First Name _____ Mi _____

Street Address _____ City _____ St _____ Zip _____

Date of Birth _____ SS# _____ Relation _____

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Patient Name _____ DOB _____ Date _____

Past Medical History (Please Circle all that Apply)

Abnormal Echo	GERD
Abnormal EKG	Heart Block
Anemia	Hypertension
Aneurysm	Hypotension
Angina	Irregular Heart Rate
Aortic Aneurysm	Liver Disorder
Arthritis	MI, Heart Attack, Cardiac Arrest
Asthma	Murmur
Atrial Fibrillation	Palpitation
Atrial Flutter	Peptic Ulcer
Bradycardia	Peripheral Vascular Disease
Cancer	Phlebitis
Cardiomyopathy	Pleurisy
Carotid Stenosis	Pulmonary Artery Hypertension
Cellulitis	Pulmonary Embolism
Cholesterol Problem	PVC
Claudication	Renal Failure
Congestive Heart Failure	Rest Leg Syndrome
Connective Tissue Disease	Rheumatic Fever
COPD	Seizure Disorder
Coronary Artery Disease	Short of Breath
CVA	Sleep Apnea
Deep Vein Thrombosis	Stroke TIA
Dementia	SVT
Diabetes	Syncope
Dialysis	Tachycardia
Diverticulitis	Thyroid Disorder
Dyslipidemia	Tuberculosis
Edema	Valvular Heart Disease
Endocarditis	Valvular Prolapse
Fatigue	Varicose Veins
Gastrointestinal Bleed	

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Patient Name _____ DOB _____ Date _____

Home Medications

Medication/ Dose/ Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

Please list all know Allergies

_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgical History

Please list Date and Details

Amputation	IVC Filter
Aneurysm Repair	Leg Bypass
Aortic Value Replacement	Lobectomy
Arteriogram	Nephrectomy
CABAG Open Heart	Pace Maker
Cardioversion	Pneumonectomy
Electrophysiology	PTCA Stents
Endarterectomy	Thyroid Surgery
Gallbladder Surgery	Value Replacement / Repair
Heart Catheterization	Watchman

Family History

Aortic Aneurysm	Father Mother Sibling Grandparent
Asthma	Father Mother Sibling Grandparent
Cancer	Father Mother Sibling Grandparent
Cholesterol Problems	Father Mother Sibling Grandparent
Congestive Heart Failure	Father Mother Sibling Grandparent
Connective Tissue Disease	Father Mother Sibling Grandparent
Coronary Heart Disease under age 55	Father Mother Sibling Grandparent
CVA or Stroke	Father Mother Sibling Grandparent

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Patient Name _____ DOB _____ Date _____

Family History Continues	
Diabetes	Father Mother Sibling Grandparent
Hypertension	Father Mother Sibling Grandparent
Peripheral Vascular Disease	Father Mother Sibling Grandparent
Pulmonary Hypertension	Father Mother Sibling Grandparent
Renal Disease	Father Mother Sibling Grandparent
Sudden Cardiac Death	Father Mother Sibling Grandparent
Thyroid Disease	Father Mother Sibling Grandparent

Any Additional Information:

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Social History

Marital status: Single, Married, Divorced, Widowed

What is/was your Occupation_____

Disabled_____

Smoking History:

Current Smoker:

Number of years _____

Cigarettes_____ packs per day

Cigars: _____number per week

Smokeless_____ amount per day

Would you like counseled to quit Yes / No

Former Smoker:

Year Quit _____

Never Smoker:

Drug use:

I use one of the following drugs:

Marijuana, Cocaine, Crack, Heroin, Illicit Prescription

Other_____

I do not use drugs:

Special Diet:

Are you on a special diet :

Calorie Limited	Low Salt
Low Fat	Diabetic
High Fiber	Low Cholesterol

I am not on a special diet:

Exercise :

Do you follow and exercise program:

How may time a week_____

Type of Exercise_____

I do not follow and exercise program

Review of Symptoms (Please circle if you have any of the following)

Respiratory

Chest congestion	Cough	Dyspnea
Hemoptysis		Pain with breathing
Shortness of Breath		Wheezing

Cardiovascular

Chest Pain	Claudication	Cold Extremities
Dizziness	Fainting	Fatigue
High Blood Pressure		Irregular Heart Beat
Leg Edema	Lightheadedness	Near Syncope

Constitutional

Fatigue	Fever	Weight Gain
Weight Loss		

Endocrine

Cold Tolerance	Polydipsia	Polyuria

ENT

Allergies	Nasal Congestion	Post Nasal Drip
Ringing in Ears	Sore Throat	

Gastrointestinal

Abdominal Pain	Blood In Stool	Change in bowel
Constipation	Diarrhea	Heartburn
Nausea	Vomiting	

Hematologic

Abnormal Bleeding	Easy Bruising

Musculoskeletal

Joint Pain	Joint Stiffness	Leg Cramps
Muscle Aches		

Neurological

Confusion	Headaches	Incoordination
Numbness	Seizures	Tremor
Weakness		

Psychosocial

Anxiety	Depression	Insomnia

Urologic

Dysuria	Hematuria	Nocturia