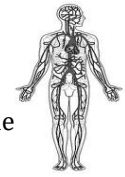
Interventional Cardiology and Vascular Consultants, P.L.C.



1206 North Mills Avenue
Orlando, Florida 32803
(407) 898-8449
Fax (407) 898-8756

181 Webb Drive, Suite B
Davenport, Florida 33837
(863) 421-9397
Fax (863) 421-9339

1026 Montana Street
Orlando, FL 32803
(407) 898-8449
Fax (407) 898-8756

4597 Casablanca Circle
Sebring, FL 33870
(863) 421-9397
Fax (863) 421-9339

Ashish Pal, M.D., F.A.C.C.
www.veinguru.com

PATIENT INFORMATION

Date: _____/_____/_____

Patient Name: _____ , _____
Last First

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**:_____

Social Security No.: _____-_____-_____ **Date of Birth:** _____/_____/_____ **Gender:** M / F / T

Email Address: _____

Marital Status: S M D W

Primary Care Physician: _____ **Referring Physician:** _____

Pharmacy: _____ **Pharmacy Phone:** _____

For Documenting Medical Statistics Only:

Race:
☐White
☐Black/African American
☐American Indian/Alaskan Native
☐Asian
☐Nat Hawaiian/Pacific Islander
☐Other: _____

Ethnicity:
Hispanic or Latino ☐Yes ☐No

Primary Language:
☐English
☐Spanish
☐Other: _____

MEDICAL INSURANCE COVERAGE

Primary Insurance: _____ Policy ID No.: _____

Group Number/Name: _____ Name of Policy Holder: _____

Policy Holder SSN: _____Policy Holder D.O.B.: _____/_____/_____

Secondary Insurance: _____ Policy ID No.: _____

Group Number/Name: _____ Name of Policy Holder: _____

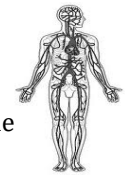
Policy Holder SSN: _____ Policy Holder D.O.B.: _____/_____/_____

I hereby give my consent to Interventional Cardiology and Vascular Consultants, PLC to release, to receive from, or exchange any form of communication regarding my medical records and other individually identifiable health information. The information may be used and disclosed for the purpose of treatment, payment, or any other Health Care Operations. I have received a copy of the provider's privacy policies, and fully understand that I may request restrictions or may revoke consent in writing at any time. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Interventional Cardiology and Vascular Consultants for any professional services rendered to me.

Patient Signature:_____ Date: _____/_____/_____

Guarantor's Signature: _____ Date: _____/_____/_____

Interventional Cardiology and Vascular Consultants, P.L.C.



1206 North Mills Avenue
Orlando, Florida 32803
(407) 898-8449
Fax (407) 898-8756

181 Webb Drive, Suite B
Davenport, Florida 33837
(863) 421-9397
Fax (863) 421-9339

1026 Montana Street
Orlando, FL 32803
(407) 898-8449
Fax (407) 898-8756

4597 Casablanca Circle
Sebring, FL 33870
(863) 421-9397
Fax (863) 421-9339

Ashish Pal, M.D., F.A.C.C.
www.veinguru.com

REQUEST AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ _____ Date: _____/_____/_____
Last First

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

Social Security No.: _____ Date of Birth: _____/_____/_____ Gender: M / F / T

I hereby understand by signing this authorization that my health information may no longer be protected by the Privacy Rule once it is disclosed by Interventional Cardiology & Vascular Consultants to another covered entity. I may revoke or restrict authorization in writing by contacting the office manager at both facilities for details. I hereby authorize the release of records listed as follows:

****FOR OFFICE USE ONLY*****

Records from the office of: _____
(Name of Physician)
Address: _____ Phone: _____

Specific records to be released: _____,

For the purpose of: _____.

To be released to: _____
(Name of Physician)
Address: _____ Phone: _____

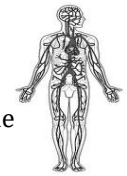
Patient Signature:_____ Date: _____/_____/_____

An individual may revoke the authorization in writing. If you refuse to consent to, or refuse to authorize the use or disclosure of your Protected Health Information for the purpose of treatment, payment, or health care operations the healthcare provider may refuse to treat the patient. There may be the potential for the protected health information to be re-disclosed by the recipient.

Confidentiality Note: The information contained in this transmission is absolutely confidential under Florida statute 155.251 and 395.017. It is intended solely for the use of the addressee listed above and no one else. If you are not the intended recipient, of the employee or agent responsible to deliver this document to the intended recipient, you are hereby notified that any dissemination, disclosure or copying of the contents of this facsimile is strictly prohibited. If you have received this communication in error, please notify us by phone immediately and return the original copy received to the address listed above. Thank you.

Provide a copy of this authorization to the patient.

Interventional Cardiology and Vascular Consultants, P.L.C.



1206 North Mills Avenue
Orlando, Florida 32803
(407) 898-8449
Fax (407) 898-8756

181 Webb Drive, Suite B
Davenport, Florida 33837
(863) 421-9397
Fax (863) 421-9339

1026 Montana Street
Orlando, FL 32803
(407) 898-8449
Fax (407) 898-8756

4597 Casablanca Circle
Sebring, FL 33870
(863) 421-9397
Fax (863) 421-9339

Ashish Pal, M.D., F.A.C.C.
www.veinguru.com

FINANCIAL AGREEMENT

Patient Name: _____ _____ D.O.B.: _____/_____/_____
Last First

If you have Medicare:

We are happy to accept assignment on all Medicare claims. Medicare pays 80% of the allowable after your yearly deductible has been met. Please understand that you are responsible for the payment of the 20% coinsurance and deductible amount. Additionally, if you have supplemental coverage after Medicare, we will bill your supplemental insurance as a courtesy to you. If for any reason your supplemental coverage does not pay, we must request payment directly from you.

If you have insurance OTHER than Medicare:

We will bill your insurance company for you, and request payment to be sent directly to us. We will make all reasonable attempts to collect appropriate payment from your insurance company, but payment in full is required within 60 days of the date of service. If for any reason your insurance company does not pay, please understand that you are fully responsible for payment of any coinsurance, deductible, and any other charges not covered by your insurance company.

Financial Agreement:

I understand and agree that, regardless of my insurance status, I am fully responsible for the balance on my account for any professional services rendered to me by Interventional Cardiology & Vascular Consultants physicians and staff. I understand and agree that, unless other payment arrangements are made, payment is expected at the time of service. Failure to make proper and timely payment on my account could result in my account being referred to an outside source for collection action, and I will be responsible for any additional charges incurred if this action is necessary.

Patient Signature: _____ **Date:** _____/_____/_____

Guarantor's Signature: _____ **Date:** _____/_____/_____

HIPAA AGREEMENT

In general, the HIPPA privacy rules give individuals the right to request restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name: _____ _____ D.O.B.: _____/_____/_____
Last First

Social Security No.: _____

I wish to be contacted in the following manner for appointments and medical correspondences:

Check all that apply:

☐ Home/Cell Phone Home/Cell Number: _____

___ Leave a message with date and time.
___ Leave message with call back number ONLY.
___ Do not leave message.

☐ Work Phone Work Number: _____

___ Leave a message with date and time.
___ Leave message with call back number ONLY.
___ Do not leave message.

☐ Written Communication/Email

___ Mail to my home address: _____
___ Send message to my email address: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Use and disclosure for reasons other than treatment, payment or operations may be permitted without prior consent in an emergency.

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of health care professionals.

I understand that I have the Right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry-out treatment, payment, or healthcare operations- and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I, hereby give consent to Interventional Cardiology and Vascular Consultants, P.L.C., to release to, receive from, or exchange any form of communication regarding my medical records and other identifiable health information. The information may be used and disclosed for the purpose of treatment, payment, or any other healthcare operations. I have received a copy of the providers' policies, and fully understand that I may request restrictions or revoke consent in writing at any time.

☐ The following names are those I give Interventional Cardiology and Vascular Consultants, P.L.C the authorization to give health information regarding appointments and medical records:

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

☐ **DO NOT** disclose any health information regarding appointments and medical records to anyone but me.

Patient Signature:_____ **Date:** ____/____/____

Witness Signature:_____ **Date:** ____/____/____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand ICVC's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that ICVC may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of ICVC's *Notice of Privacy Practices* by submitting a request in writing for a current copy of ICVC 's *Notice of Privacy Practices*.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For ICVC Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative. ICVC made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

_____ Patient or patient's personal representative refused to sign

_____ Patient or patient's personal representative unable to sign

_____ Other_____

_____
Employee Name (printed)

_____ _____
Employee Signature Date

Interventional Cardiology and Vascular Consultants, P.L.C.

Notice of Privacy Practices
Effective Date: 09/23/2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances

or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim for damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Interventional Cardiology and Vascular Consultants, P.L.C.).* If you have questions and would like additional information, you may contact us at 407-898-8449.