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Delta Convenient Care, PC

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PATIENT INFORMATION REGISTRATION FORM

(Please print clearly)

Patient's Full Name: ____Age: __________ Sex: □ M □ F

Date of Birth: _______________________ Social Security No.:___________________________________

Address: ____________________________City: ______________ State: ___________Zip: ____________

Are you: □ Married □ Single □ Divorced □ Separated □ Widowed

Home Phone: __________________________Cell Phone: ______________________________

Patient's Employer: ______________________________________ Phone No.:____________________

Address: ____ Occupation: _______________________

City: ____________State:__________ Zip: _____________Spouse: _________

Spouse's Employer: _________________________________ Phone No.:_________________________

Occupation: _________________________ _______________ Spouse Date of Birth: ________________

Please check one: **Race:** □ Black □ White □ Hispanic □ other ____________________□ Prefer not to answer

Please check one: **Preferred Language**: □ English □ Spanish □ other _______________□ Prefer not to answer

Please check one: **Ethnicity:** □ White American □ Hispanic/Latino □ African American □ Asian American

□ American Indian □ mixed □ other _________________________□ Prefer not to answer

In case of emergency contact (other than spouse):____

Address: ____

City: ____ State: ______________ Zip: __________________

Relationship: _______________________________________ Phone No: ___________________________

REFERRAL INFORMATION: (Please tell us how you were referred to our practice)

Physician/Other: ____

PRIMARY INSURANCE CARRIER NAME:____

TREATMENT AUTHORIZATION:

I hereby authorize Delta Convenient Care, P.C. and its associates to undertake medical treatment, diagnostic testing as deemed medically necessary.

PATIENT CONFIDENTIALITY:

I, _______________ authorize you to speak with my **(circle)** spouse son daughter other ______________________ about anything related to my health including but not limited to my medical condition and medications I'm currently taking and any and all other information that will be helpful pertaining to me, or to help me remain stable while in your care. For authorization to speak to my family member when calling, I will provide them with a password. The password is _____________.

PAYMENT AUTHORIZATION:

I, _________________________________ hereby authorize ______________________________, M.D. to furnish information concerning services rendered. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photo static copy of this authorization will be as valid as the original. In the event my account should become delinquent, I will be responsible for all collection fees. These fees will include a 15% service charge and any legal fees incurred through the collection process. **NOTE:** All payments due because of patient's failure to cancel appointment will be billed direct to the patient for payment. Reimbursement from Insurance will be patient's responsibility. Obtaining referral information is the patient's responsibility.

**** ALL CO-PAYS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED ****

____ ___________________

SIGNATURE (PATIENT OR PARENT IF UNDER 18 YEARS OF AGE) **DATE**

SELF PAY PATIENTS: Delta Convenient Care, PC is happy to serve patients that do not have insurance and/or patients that are self-pay. It should be noted that deposits are required for the services listed below on the day that the service is rendered.

Procedure	Deposit Required	Procedure	Deposit Required
Office Visit – Established Patient	$ 50.00	Holter Monitor	$ 75.00
Office Visit – New Patient	$ 100.00	Heart Catheter	$ 250.00
Echocardiogram	$ 200.00	Peripheral	$ 600.00
Echo with Contrast	$ 250.00	PPM/AICD Insertion	$ 250.00
Vascular Ultrasound	$ 200.00	ABI	$ 100.00
CT/CTA Scan	$ 400.00	PFT	$ 75.00
Stress Test – with Nuclear Medicine	$ 400.00	Thyroid Biopsy	$ 200.00
Stress Test – Treadmill Only	$ 100.00	Venous Ablations	$ 600.00
Renal Ultrasound	$ 50.00	EECP	Speak to billing

I understand that as a self-pay patient, I am responsible for the above listed deposit amounts for services provided by Delta Convenient Care, PC on the day the services are delivered. I will be billed for the remaining amount of the cost of the service.

____

Signature (Patient or parent if under 18 years of age)

Advance Directives

Are you interested in learning about advance directives regarding your health care? (This is a written document in which you specify what type of medical care you want if in the future, you lose the ability to make that decision).

Yes, I am interested ___________ No, I am not interested at this time ______________

Patient Signature: ____ Date: ________________

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Nurse Practitioners Agreement

Delta Convenient Care and the Heart and Vascular Center of West Tennessee are committed to providing the highest quality, state-of-the-art medical care for all of our patients. As part of this commitment, our physicians utilize Nurse Practitioners to assist in the delivery of your care. Each Nurse Practitioner works in partnership with you and the Physician to assess your healthcare needs, prescribe necessary treatment and services, and to monitor your progress toward optimal health.

We are confident in the care you will receive from each of our providers. Our Nurse Practitioners work under the direct supervision of the Physician. Please indicate whether or not you agree to receive care from our Nurse Practitioners by checking one of the statements below:

___I agree to see a Nurse Practitioner as part of my care at Delta Convenient Care and the Heart and Vascular Center of West Tennessee.

___I do not agree to see a Nurse Practitioner as part of my care at Delta Convenient Care and the Heart and Vascular Center of West Tennessee.

______________________________ _______________
Please print patient's name Date of Birth

______________________________ _______________
Patient Signature Date

Updated: 03182014

Notice of Privacy Practices for Protected Health Information

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!

If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office/hospital. You have the following rights with respect to your Protected Health Information:

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office/hospital—we are not required to grant the request but we will comply with any request granted;
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
3. Right to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office/hospital using the form we provide to you upon request;
4. Right to appeal a denial of access to your protected health information except in certain circumstances;
5. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office/hospital using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
6. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office/hospital using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
7. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital using the form we give you upon request.

If you want to exercise any of the above rights, please contact **Compliance Manager; 17 Centre Plaza Drive; Jackson TN 38305 (731) 512-0104** in person or in writing, during normal hours. S[he] will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Compliance Manager; 17 Centre Plaza Drive; Jackson TN 38305 (731) 512-0104.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **the Compliance Manager.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is:
Roosevelt Freeman, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (404)562-7886
FAX (404)562-7881
TDD (404)331-2867

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule

Patient Contact

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may contact you as part of a fund raising effort for the practice.

Notification – Opportunity to Agree or Object

Unless you object we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family - Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

We may use and disclose your protected health information to assist in disaster relief efforts.

Opportunity to Agree or Object Not Required

PUBLIC HEALTH ACTIVITIES

CONTROLLING DISEASE - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

CHILD ABUSE & NEGLECT - We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.

FOOD AND DRUG AMINISTRATION (FDA) - We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE
We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.

OVERSIGHT AGENCIES
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.

LAW ENFORCEMENT
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS
We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

ORGAN PROCUREMENT ORGANIZATIONS
Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.

RESEARCH
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

THREAT TO HEALTH AND SAFETY
To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

FOR SPECIALIZED GOVERNMENTAL FUNCTIONS
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

CORRECTIONAL INSTITUTIONS
If you are an inmate of a correctional institution, we may disclose to the institution or it's agents the protected health information necessary for your health and the health and safety of other individuals.

WORKERS COMPENSATION
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses and Disclosures

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Websites www.heartvascular.net

Effective Date: ***Revised 03/18/2014***

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been presented with a copy of Delta Clinic's Notice of Privacy Practices for Protected Health Information, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____
____
____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Please print patient's name: ______________________________ Date of Birth:________________

Signature:____ Date: ____________________

If not signed by a patient, please indicate relationship to patient (e.g. spouse).

Relationship: ____________________________________ Witnessed by: ______________________

OFFICE USE ONLY:

Patient or patient's representative refuses to sign acknowledgement or receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): ____

By (name and title):____