NOTICE OF PATIENT PRIVACY AND HIPAA FORM

This policy describes how medical information can be used and disclosed. It also explains how you can get access to this information. Please review carefully.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Without your consent, we may use your health information:
To obtain payment for your treatment
To continue or coordinate your treatment
For Administrative purposes such as evaluation/quality of care

Subject to certain requirements, we may give out health information without your authorization for public health purpose, abuse and neglect reporting, health planning, auditing purposes, research studies, funeral arrangement and organ donation, worker compensation purposes and emergencies. We may provide information required by law, such as for law enforcement in specific circumstances, In any other situation, we will ask for your written authorization or require a written authorization from any other entity requesting your medical records and/or personal health We may use or disclose identifiable health information about you without your authorization for several other reasons. Information i.e. Record copy services, attorneys etc. You may later revoke any signed written authorization form and stop any future uses and disclosure.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or obtain a copy of your medical records and/or personal health information our office has pertaining to you. If you request records, our office has a three day waiting period for these records to be produced. These records are to be picked up at our office. We will not mail them to your home or another address since this information is personal in nature. You also have the right to receive a list of instances where we have disclosed health information about you for any reason.

You may request in writing, for us not to use or disclose your information for any reason except when specifically authorized by you, when required by law or in emergency circumstances. We will consider your request but are not legally required to accept it.

OUR LEGAL DUTY

We are required by law to protect the privacy of your medical information, provide this notice about our information practices and follow them as described in this notice. All employees of Ganesh Ramaswami, M.D.P.C are fully trained on this policy and the confidentiality practices of our office. If you have further concern or questions regarding this notice please ask to speak to the office manager.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised Notice effective for the health information we already have about you as well as any information we receive in the future. Our office will always have a copy of this NOTICE posted in our office for your review.

TAYLOR VEIN SOLUTIONS

VEIN & SURGERY CENTER

Communication Preferences and Message Consent:

Patient Authorization to Receive Communications by Alternative Means

Patient Name:_____ **DOB**:_____

The HIPAA Privacy Law gives patients the right to request and receive provider communications that may contain their protected health information (PHI) through alternative methods or locations. The law also allows TVS to send communications to patients about appointments, treatment and healthcare operations, and the products and services we offer. The ability to communicate with patients and coordinate their care is important to their overall health care experience and outcome success.

To support your rights and ensure TVS can contact you, please define your communication and message preferences using this form.

Directions:

Please circle either "Yes" or "No" to the questions below and provide the requested contact numbers and information to inform TVS how best to communicate with you.

Yes / No 1. You may call my **home phone** (_____-_____-_____) and leave a voice message.

Yes / No 2. You may leave a **message with anyone** answering my **home phone**

Yes / No 3. You may call and leave a message on my **cell phone** (_____-_____-_____)

Yes / No 4. You may send **text messages** to my **cell phone**

Yes / No 5. You may leave a message on my **work voice mail** (_____-_____-_____)

Yes / No 6. You may send email to my **email address**_____

Yes / No 7. Please direct written communications to my **home address**. (If No, please define address below):

Alternative Address: □ Other Residence □ Work □ Other:_____

_____

Patient Communication Consent:

By my signature below, I give express written consent and authorize TVS to contact me using the alternative methods listed above, and I will hold TVS harmless from any liability that may arise from the release of information. I understand it is my responsibility to notify TVS in writing of any changes in my contact preferences indicated above. I also understand that I may 'opt-out' of any communication(s) at any time, and that the consent will remain enforce unless otherwise revoked in writing by me and submitted to TVS.

_____ _____

Signature of Patient or Guardian Date

VEIN & SURGERY CENTER

Patient Consent, Assignment of Benefits and Acknowledgement Form

Patient Name: _____ **DOB:** _____

Consent for Treatment

I hereby authorize Taylor Vein Solutions, through its appropriate personnel, to perform or have performed upon me appropriate assessment and treatment procedures. I hereby agree and give my consent to the providers/staff of TVS to order, prescribe and provide diagnostic medical and surgical treatment to me that they judge is appropriate in diagnosing and/or treating my medical condition(s)
Patient/Guarantor Signature _____Date _____

Assignment of Insurance Benefits & Financial Agreement

The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures. Payment for services is due at the time service is rendered. We accept cash, checks, money orders, debit cards, MasterCard, Visa and Discover. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that whatever the insurance does not pay; the balance is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE.** You are responsible for knowing your insurance/auto/work comp benefits. What are covered services in your plan? Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in the plan? If you are an HMO member, you are responsible for KNOWING your PCP and/or carrier. Patients are responsible for deductible balances, co-insurance and non-covered amounts at the time of service**.** Any billed balances are due within 30 days of the statement date. .

Remember that insurance authorizations/referrals for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Interest on past due balances will accrue at a rate of 1.5% monthly. There will be a $30.00 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees. Collection costs are calculated by adding to the principle the greater of $25 or an amount 35% in excess of the balance owed.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. The Practice will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described:
Patient/Guarantor Signature _____ Date _____

I request that payment of authorized Medicare/or any third party benefits be made to the Ganesh Ramaswami, M.D, P.C on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents or any third party payor any information to determine these benefits or the benefits payable for related service.

In the event that you are unable to meet your payment obligation, we will be happy to enter into a payment plan with you.

_____ _____
Printed Name of Patient/Responsible Party Signature of Patient/Responsible Party

_____ _____
Patient Date of Birth Date