Authorization for Communication of Protected Health Information / Patient Privacy Notice

Patient Name (Last, First):	Date:

It is frequently necessary for personnel at this practice to communicate information about treatment, instructions, payment and other items of protected health information with our patients. It is not always possible to speak personally with the patient, therefore we may need to leave this information. In the event that our personnel are not able to speak with you (the patient) directly, please provide us instructions about communicating it to you.

How may we contact you? (Circle ALL that apply)

Text Cell Phone Call Cell Phone Call Home Phone Call Work Phone Email

Voicemails containing medical information can be left on: (Circle ALL that apply)

Cell Phone Home Phone Work Phone None

Due to the 1996 HIPPA Privacy Act we are not allowed to disclose, copy, transfer, email, fax, mail, etc. any protected health information to anyone without your written consent. Every effort is made to keep your records safe and secure. Upon request, you have the right to have a copy of our written privacy policy at Bay Area Heart.
By signing below, you are authorizing us to disclose your medical records by mail or secure email or in person to:

- Myself
- Primary Care Physician on file
- Referring physician on file
- Family members as listed:

Name _____ Relationship _____

Name _____ Relationship _____

I acknowledge that I have received a copy of our Notice of Privacy Practices related to your treatment at Bay Area Heart. In the event that you would like your medical records sent on your behalf to a third party, a Medical Records Release, signed by the patient, is necessary. If you have elected to authorize a family member to receive your records, Bay Area Heart cannot be held responsible, under the HIPPA Privacy Act, for redisclosure of this information to a third party. You have the right to revoke or change this authorization at any time as long as it is done via a written request to the treating physician's office.

Patient Signature _____ Date _____

Patient Financial Responsibility Release

Patient Name (Last, First):	Date:

Your signature below forms a binding agreement between Bay Area Heart and the Patient who is receiving medical services or the Responsible Party. Responsible Party is the individual who is financially responsible for payment of medical care.

- Bay Area Heart will assist you by billing to our contracted insurance providers. However, the patient is required to provide us with the most correct and updated information about their insurance and any changes in phone numbers or addresses, and will be responsible for any charges incurred if the information provided is not correct or updated in a timely manner.
- Patients are responsible for the payment of their **specialist** co-pays for each office visit, coinsurance, deductibles, and complete out of pocket expenses.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Bay Area Heart. These charges may include (but are not limited to):
  - Charge for returned checks - **$25.00 fee**
  - Charge for release of medical records (copy/fax) **$25.00 fee**
- **We require 24-hour notice if you cancel/reschedule any office visit. You may notify us by phone, email, or message through the patient portal, Healow. If you fail to notify us at least 24 hours in advance, you will be charged a no-show fee.**
  - Physician or Nurse Practitioner visit **$50 fee**
  - Ultrasounds, Stress Test, or any in office procedures **$250 fee**
  - PET CT or Nuclear Medicine **$500 fee**

Patient Authorizations:

- By my signature below, I hereby authorize Bay Area Heart to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies and other third-party payers, to obtain authorization for my treatment plan.
- I understand that it is ultimately my responsibility to ensure that proper authorization has been granted by my insurance company prior to my procedures. If I am treated and no authorization was obtained and the services are denied by my insurance company, I am then held financially responsible for that date of service and treatment cost.

For your convenience we do accept cash, checks, MasterCard, Visa and Discover.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as a Responsible Party, and that it is my responsibility to know the terms of my insurance.

Patient name: _____ Signature: _____ Date: ____

BAY AREA HEART
Cardiovascular Center of Excellence

No-Show Policy Form

Patients Name: _____ DOB: _____

We require 24-hour notice if you cancel/reschedule any office visit. You may notify us by phone, email, or message through the patient portal, Healow. If you fail to notify us at least 24 hours in advance, you will be charged a no-show fee.

- Physician or Nurse Practitioner visit $50 fee
- Ultrasounds, Stress Test, or any in office procedures $250 fee
- PET CT or Nuclear Medicine $500 fee

Please contact us at 832-905-5940 or email info@bahgoroshealth.com.

Acknowledgement of Terms:

Patient Signature: _____ Date: _____

Notice of Privacy Practices

This Notice of Privacy Practices describes how your health information and other private information about you may be used and disclosed, and further, how you may request access to this information.

Please review this notice carefully.

You have privacy rights under Texas and Federal health Insurance portability and Accountability Act of 1996 **(HIPPA).** These laws protect your privacy, but also permit us, as covered healthcare providers to use and disclose your information about your treatment, payment and healthcare operation purposes, and to disclose your information to others if the law requires it.

- *This information is available to individuals with disabilities by calling our office.*

Why do we use and disclose your personal Information?

- To decide what services you are eligible for
- To distinguish you from other individuals with the same last name
- To provide you with medical health, financial or social services that you may need
- To determine if you can pay for services
- To undertake research, audits, and evaluations of our programs
- To investigate reports of people who may lie about the help they may need
- To collect payment from private or public insurance companies for your care

Are you obligated to answer the questions we ask you?

- Generally, the law does not require you to give us information we request.
- Your social security number is required in order to provide you with some forms of financial help, or for purposes of child support enforcement.

What will happen if you refuse to answer the questions we ask you?

- Without necessary information, we may not be able to help you.
- If you purposely give us the wrong information, you may be investigated and charged with fraud.

With whom may we share your information with?

We may provide your information to the following agencies to help you or for investigative purposes:

- U.S Department of Agriculture
- U.S Department of Health and Human Services
- U.S Department of Labor
- U.S Citizenship and Immigration Services
- Internal Revenue Service
- Social Security Administration
- American Indian tribes (If applicable)
- State hospitals or long term care facilities
- Court officials
- Anyone under contract with (Bay Area Heart)
- Local and State Health Departments
- Child or adult protection agencies or Investigators
- Other human services offices, including child support enforcement offices
- Fraud prevention units
- Employees or volunteers of any welfare agency who need the information to carry out their mandates.
- Court attorney, attorney general or law enforcement officials
- Ombudsman for families
- Other healthcare providers
- Coroner/ medical examiner
- Others who pay for your care
- Insurance companies from which you or your children receive benefits
- Manages care organizations about you healthcare benefits
- Collection agencies
- Anyone else to whom the law stipulates we may disclose information to

Your Rights

- You have the right to review the information we have about you
- You may request copies of the information we have about you
- You may authorize other individuals to see and retain copies of the information about you
- We will only use and disclose your health information for the purposes listed above, unless we obtain a special written authorization from you
- You may question the accuracy of any information we retain about you. You may send your concerns in writing, explaining why the information is not accurate or complete, your explanation will be attached anytime the information is shared with another agency
- You have the right to request that we share information with you by alternative means or at an alternative location. If we find that your request is reasonable, we will abide by it
- You may request in writing restrictions on the uses and disclosures of your health information. Your request must stipulate what information you want to restrict and to whom you want these restrictions to apply. We are not required to accept your request. You may revoke the restrictions at any time by calling us or writing to us
- You have the right to receive a record of each time we share your health information for 6 years from date it is shared effective September 1, 2015. This record will not include disclosers made to treat you, pay or bill for your healthcare services, or carry out healthcare operations
- Parents of a child under 18 years of age may see information about that child unless Texas provision on a minors privacy rights with respect to his or her parents
- You may file a complaint if you feel your privacy rights have been violated. We cannot retaliate against you (e.g, refuse your treatment, or treat you badly) for making a complaint against us. Complaints about your physician, as well as other licensees and registrants of the Texas Medical Board, including assistants, may be reported for investigation to the following address: **Texas State Board of Medical Examiners PO Box 2018 Austin, TX 78768-2018. For assistance by phone, call:** 800-248-4062**.**
- Bay Area Heart is committed to providing quality patient care and promoting patient/family satisfaction. Should you have any concerns or complaint concerning privacy/patient confidentiality, please contact our Practice Manger to resolve your matter promptly at 832-905-5940.

Please note that we may change our Notice in the future. When we change our Notice, we will post the modification in our main service location.

Effective date of this Notice: (September 1, 2015)