Cardiac and Vascular Consultants

Authorization for Treatment / Release of Information

Consent to Treatment: The patient and/ or authorized representative do hereby consent to any and all treatments which may deem advisable by the physician or Cardiac and Vascular Consultants, Inc. Patient Consent to Rx verification, Electronic Data Health Exchange (eEHX Interoperability). Each procedure and diagnostic study will be discussed in detail with the patient before the procedure is performed. Additional consent will be required at the time of the procedure.

Assignment of Insurance Benefits: I assign payment directly to Cardiac and Vascular Consultants, Inc. Insurance Benefits otherwise payable to me. I understand that I am financially responsible for the charges paid by this assignment. I will assist in the collection of my insurance should there be any delay in payment. I agree to actively participate in collecting Insurance payment for any claims unpaid after 30 days. If after 45 days the claim remains unpaid, I understand the balance will be due from me.

Medicare Patients: I certify that the information given by me in applying for payment under the XVIII if the Social Security is correct. I authorize Cardiac and Vascular Consultants, Inc. to release to the Health Care Financing Administration of its Intermediaries any information needed for this related Medicare claim, I hereby authorize payment directly to Cardiac and Vascular Consultants, Inc for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payments as may be due by other third-party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as but limited to routine testing may not be covered by Medicare unless the Physician provides medical necessity.

Patient/ Guarantor Agreement: I understand that Cardiac and Vascular Consultants, Inc. is not in business expanding credit. Therefore, it is the policy of Cardiac and Vascular Consultants, Inc. to require payment in full at the time of service. If unable to pay the due balance in full at the time of service, I agree to make prior arrangements with the Billing Department.

I understand that I am financially responsible for my/ the patient's account with Cardiac and Vascular Consultants, Inc. regardless of my insurance benefits. I authorize copies of this form to be valid as the original.

Patient/ Responsible Party: _____

_____ _____ _____ _____

Patient or Legal Representative Signature **Date** **Witness Signature** **Date**

Creekside Medical Plaza, 1050 Old Camp Rd., Ste. 270, The Villages, FL 32162, * LRMC Medical Plaza, 709 Physician's Ct., Leesburg, FL 34485
Sabal Palms Plaza, 510 Hwy 466, Ste. 105/106, Lady Lake, FL 32158, * Wildwood: 4056 SR East 44, Wildwood, Fl 34785
Ph 352-461-3998, Fax: 352-633-1969
Lecanto:4224 west Gulf To Lake Highway, Lecanto, FL*34461*Ph:352-513-3482*Fax:352-513-3489

Web: www.cvcfl.com

Cardiac and Vascular Consultants

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Cardiac and Vascular Consultants to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

I have the right to review the Notice of Privacy Practices before signing this consent. Cardiac and Vascular Consultants reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cardiac and Vascular Consultants.

With this consent, Cardiac and Vascular Consultants may call my home or other alternative location and leave a message on voice mail or e-mail/text me, and publish my records to the patient portal about any items that assist the practice in carrying out TPO. This may include appointment reminders, insurance issues, and concerns with my clinical care, such as laboratory test results, diagnostic imaging, Integrated Data records Exchange (eEHX), Marketing, etc.

With this consent, Cardiac and Vascular Consultants may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Cardiac and Vascular Consultants may text or e-mail to my home or alternative location, any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, and medical records. I have the right to request that Cardiac and Vascular Consultants restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Cardiac and Vascular Consultants to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, or later revoke it, Cardiac and Vascular Consultants may decline to provide treatment to me.

Patient Name Printed: _____

_____ _____ _____ _____

Patient or Legal Representative Signature **Date** **Witness Signature** **Date**

Cardiac and Vascular Consultants

Authorization For Release Of Medical Information

Date: _____

I _____ authorize _____("Provider") of Cardiac and Vascular Consultants, to disclose protected health information ("PHI") regarding:

Patient Name: _____ DOB _____, Address: _____

I authorize the PHI to be disclosed at my individual request to **Cardiac and Vascular Consultants** at the following location:

___ Creekside Medical Plaza 1050 Old Camp Road Ste. 270 The Villages, FL 32162 Ph: 352-633-1966* Fax: 352-633-1969

___ Conard Plaza 4224 West Gulf To Lake Highway, Lecanto, FL 34461* Ph: 352-513-3482*Fax: 352-513-3489

Check One: **I authorize the following PHI to be released by Paper, Electronically Shared, Integrated Data Exchange:**

__All health information about the patient in the possession of Provider, including, but not limited to psychiatric, and mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information, or alcohol or drug treatment information good for **one year** of the date signed.

__For a **limited time beginning**_____ **and ending**_____ all health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information.

__Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed**(ii):**_____.

__Other, as described here: _____.

Release PHI (To) or (Obtain PHI) from:

Name of Organization/Person	
Address of Organization:	
Phone Number:	**Fax Number:**

(i) Psychotherapy notes are notes by a mental health professional documenting private counseling stored separately from the chart. To release them requires a separate release.

(ii) The Provider is authorized by law to use or disclose PHI for a variety of reasons without the patient's authorization. Please see the Provider's Notice of Privacy Practice for details.

This Authorization was developed to comply with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, the Health Information Technology for Economic and Clinical Health (HITECH) Act, the American Recovery and Reinvestment Act (ARRA) of 2009, and associated regulations.

_____ _____ _____ _____

Patient or Legal Representative Signature **Date** **Witness Signature** **Date**

Cardiac and Vascular Consultants

ADVANCED DIRECTIVES

(For Compliance with the Patient Self-Determination Act)

Patient Name: _____ DOB: _____

Have you executed an Advanced Directive? YES _____ NO _____

If YES, is this directive in the form of:

____ A Living Will

____ A Durable Power of Attorney

____ A Health Care Surrogate (Someone to make decisions for you)

____ DNR (Do Not Resuscitate)

Have you provided this office with a copy of Advanced Directive?

YES _____ NO _____

If you would like more information regarding advanced directives please ask the nurse or receptionist. **All forms are provided in the lobby**

I have been provided with information regarding the "PATIENT SELF-DETERMINATION ACT"

_____ _____

Signature of patient or representative Date

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Communications Refusal

I, _____, recommend being contacted by Cardiac and Vascular Consultant, by the following communication indicated below.

Telephone Communication	___ Accept	___Reject
Written Communication	___ Accept	___Reject
Text Messaging	___ Accept	___Reject
Email	___ Accept	___Reject
Patient Portal	___ Accept	___Reject
Appointment Confirmation	___ Accept	___Reject
Test Result	___ Accept	___Reject

_____ **I refuse <u>ALL</u> of the above communications**. I understand that this means that the office will not be able to communicate with me in any way and I understand the risks involved. Should an emergent test result or situation arise, the office/ physician will not be able to contact me in any way.

Please be aware that due to HIPAA compliance, this form will be adhered to and not deviated from. You may change your designations above by filling out a new form and submitting it to the office. The form is in effect for one year, unless written notification is given otherwise.

Patient Signature _____ Date: _____

Witness Signature _____ Date: _____

Cardiac and Vascular Consultants

Please answer all the questions:

The below questions are required to be asked by State Law for Census

Sexual Orientation

Check Mark	Name	
	Lesbian, gay, or homosexual	38628009
	Straight or heterosexual	20430005
	Bisexual	42035005
	Do not know	UNK
	Choose not to disclose	ASKU
	Something else, please describe:	OTH

Gender Identity

Check Mark	Name	
	Male	446151000124109
	Female	446141000124107
	Female-to-Male (FTM) / Transgender Male/Trans Man	407377005
	Male-to-Female (MTF) / Transgender Female/Trans Woman	407376001
	Genderqueer, neither exclusively male nor female	446131000124102
	Choose not to disclose	ASKU
	Additional gender category or other, please specify	OTH

☐ Transgender

Patient Signature: _____ **Date**: _____