Memphis Cardiology & Vein Center **Patient Information**

*****PLEASE FILL OUT ALL SECTIONS OF THIS FORM*****

Date: _____ Circle one: Cardiology Consult or Vein Consult

Patient Name: _____ Date of Birth: _____

Sex: _____ Social Security Number: _____

Ethnic Group: Hispanic or Latino / NOT Hispanic or Latino

Race: _____ Language: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Employer: _____ Work Phone Number: _____

Email address: _____

How did you hear about us? TV INTERNET MAGAZINE OTHER _____

Marital Status: S M D W Sep Spouse Name: _____

*Does patient have a Living Will – Yes or No If yes, please provide a copy to the front desk.

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ Alternate Phone Number: _____

Referring Dr: _____ Primary Dr: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Primary Insurance Company: _____ Copay: _____

Policy Number: _____ Group Number: _____

Primary Policy Holder: _____ Date of Birth: _____

Social Security Number: _____ Relationship: _____

Secondary Insurance Company: _____ Copay: _____

Policy Number: _____ Group Number: _____

Secondary Policy Holder: _____ Date of Birth: _____

Social Security Number: _____ Relationship: _____

*****IF Patient is a Minor (under 18) please provide Parent/Guardian information below:**

Parent/Guardian Name: _____ Relationship to patient: _____

SSN: _____ DOB: _____ Phone Number: _____

Address: _____

Memphis Cardiology & Vein Center

Kishore K. Arcot, M.D., F.A.C.C., F.S.C.A.I.
Board Certified in Interventional Cardiology
Board Certified in Venous and Lymphatic Medicine
Board Certified in Vascular Medicine
Board Certified in Endovascular Medicine

Cathy Chandler, RN
Office Manager

6005 Park Avenue, Suite 225-B
Memphis, Tennessee 38119

901.767.6765
Fax 901.767.9639

www.memphisvein.com

Date: _____

Patient Name: _____

DOB: _____

SSN: _____

Authorization to Provide Treatment
Insurance Assignment and Release

I hereby authorize Memphis Cardiology, PLC and its physicians, or any other physician authorized by this company, to provide such medical services, either regular or emergency, as may be determined by the physician to be in my best interests (or the interests of my dependent if I am signing as a parent or guardian).

I further authorize Memphis Cardiology, PLC or his agents to furnish Medicare, insurance carriers or other Third-party payers information concerning my illness and treatments. I hereby assign to the physicians all payments for medical services rendered to myself or my dependents.

In those cases where payment is not collected at the time of services, I understand that I am responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by others within 60 days from the date billed unless there are other agreements between me or my insurance company and Memphis Cardiology, PLC.

I agree to pay all collection costs including but not limited to bad check charges, court costs, witness expenses and reasonable attorney's fees if it becomes necessary to turn this account over to an outside party for collection. I further agree to pay interest charges of 1% per month on any balance remaining on this account beginning 60 days from the date of service.

These authorizations and release remain in effect until I choose to revoke them by delivering a written statement to Memphis Cardiology, PLC.

Patient / Responsible Party: _____

Date: _____

*Medicare Patients with Medigap Insurance

I request that payment of authorized Medigap benefits be made on my behalf to Memphis Cardiology, PLC, for any services furnished to me by that supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits.

This authorization is in effect until I choose to revoke it by delivering a written statement to Memphis Cardiology, PLC.

Patient / Responsible Party: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This notice took effect on April 14, 2003, and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the change. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our privacy notice at any time by contacting our privacy officer, Cathy Chandler. Information on contacting us can be found at the end of this notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may be disclosed to your family, friends, and/or other person you choose to involve in your care only if you agree that we may do so.

Payment: We may disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and my included insurance organizations or other business that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition, or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoenas, discovery request or other lawful processes). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to voicemail messages, postcards, or letters.

Memphis Cardiology & Vein Center 6005 Park Ave, Ste 225B, Memphis, TN 38119 Phone - 901-767-6765 Fax - 901-767-9639

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices.

_____

Please Print Your Name Here

_____

Please Sign Your Name Here

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because

- o The patient refused to sign.
- o Due to an emergency situation it was not possible to obtain an acknowledgement.
- o We were not able to communicate with the patient.
- o Other (Please provide specific details.)

_____

_____

_____

_____ _____

Employee Signature Date

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state law