VASCULAR & VEIN CENTER
at Gulfcoast Surgeons

Diplomates of the American Board of General & Vascular Surgery
Abraham Sadighi, MD, FACS
Michael Novotney, MD, FACS
Angela Echeverria, MD
Erika Kelly, DNP, ARNP
Kathleen Foiles, ARNP

WELCOME TO OUR PRACTICE

_____
Patient Name

We are pleased that you have chosen Vascular & Vein Center at Gulfcoast Surgeons for your surgical needs.

Your appointment is on _____ at _____AM/PM with Dr. _____.

Enclosed you will find an information packet which must be completed and brought to our office at the time of your appointment. Please arrive ten (10) minutes early for your appointment with your photo I.D, insurance cards, and all your current medications bottles with you.

If your insurance company requires an authorization for you to receive treatment from a specialist, you and your primary care physician must obtain this prior to your appointment.

If we can be of service to you, please do not hesitate to call us. We look forward to seeing you.

☐ 8010 Summerlin Lakes Dr. Ste 100
Fort Myers, FL 33907

☐ 1003 Del Prado Blvd. S. Ste 204
Cape Coral, FL 33990

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PATIENT REGISTRATION

Name: _____ Date of Birth: ___/___/_____

Local Address: _____ City _____State ____ Zip_____

Alternate Address: _____ City_____ State ____ Zip_____

Home Phone No: _____ **Alternate Phone No: _____**

Employer: _____ **Work Phone No: _____**

Social Security No: _____ **Sex: ____ Marital Status: _____**

Spouse Name: _____ **Spouse Birthdate: _____**

Spouse SS#: _____ **Spouse Employer: _____**

Referring Physician: _____ **Primary Care Physician: _____**

Emergency Contact: _____ Phone: ( ) _____

How did you hear about us? Friend___ Newspaper___ TV___ Physician ___Telephone Book ___ Other _____

Have you recently been in a Skilled Nursing Facility or Rehab Facility? ___ Dates of Stay: _____

Primary Insurance Carrier: _____

Insured's Name: _____Insured's Date of Birth: _____/_____/_____

Policy Number: _____Group Number: _____

Secondary Insurance Carrier: _____

Insured's Name: _____Insured's Date of Birth: _____/_____/_____

Policy Number: _____ Group Number: _____

I hereby verify that the above information is accurate. I fully acknowledge that payment is based solely on my contract with an insurance company or government agency, and I do agree to pay for services not fully reimbursed by them. I authorize the release of all medical information necessary to process the claim. I authorize all benefits payable to be assigned and made payable to Vascular & Vein Center at Gulfcoast Surgeons on my behalf. In the event that the procedure billed is deemed non-covered, full payment is not received, my deductible has not been satisfied, or for any reason whatsoever the insurance company does not make full and prompt payment to Vascular & Vein Center at Gulfcoast Surgeons, I agree to settle the account in full with Vascular & Vein Center at Gulfcoast Surgeons upon notice of the failure of my insurance company to pay. I authorize the release of any and all of my medical records to any physician and/or hospital participating in my care.

Patient Signature: _____Date: _____/_____/_____

NOTICE OF PRIVACY PRACTICES

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

EFFECTIVE DATE IS SEPTEMBER 23, 2013

WE WILL COMPLY WITH THIS NOTICE.
This Notice describes the privacy practices of Gulfcoast Vascular Surgeons, our providers, our pharmacies, and any third parties that help us manage Protected Health Information. In general, we may use and disclose your health information to coordinate and oversee your medical treatment, pay your medical claims, and assist in health care operations as described in this Notice.

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION.
We believe that information about you and your health, whether it be in verbal, written, or electronic format is personal and should be carefully safeguarded. We are committed to protecting your personal health information. We (or the third parties that assist us) maintain a record of all health care provided by or paid for by Gulfcoast Vascular Surgeons. This Notice applies to all of your health information that we maintain. Please be aware that health care providers or pharmacies not associated with us, such as other doctors, hospitals, or outside pharmacies, have their own policies regarding their use and disclosure of your health information created in their offices. You should consult their Notice of Privacy Practices for information about how they may use and disclose your health information.

This Notice informs you about the ways we may use and disclose your health information. This Notice also describes your privacy rights, along with the obligations that we have regarding the use and disclosure of your health information. Federal medical privacy law requires us to:

-make sure your health information is kept private
-give you this Notice of Privacy Practices with respect to your health information; and
-to follow the terms of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
We do not sell your personal health information or disclose it to companies that wish to sell you their products. We must have your written permission (called an "authorization") to use and disclose your health information, except for the uses and Disclosures described below. We do not sell your health information to anyone or disclose your health information to other companies who may want to sell your health information to anyone or disclose your health information to other companies who may want to sell their products to you (e.g. catalog or telemarketing firms). Additionally, Florida law may require that we obtain your specific prior authorization to use and disclose certain health information, such as behavioral health, substance abuse and HIV/AIDS information.

***You and Your Personal Representative*.** We may disclose your health information to you or your personal representative (an individual who has the legal right to act on your behalf).

***Others Involved In Your Care*.** We may share your health information with family members or friends who are directlycare, when you are present and have given us verbal or written permission. We will not discuss your health information with your family or friends if you are not present unless you have given us your permission or we believe it is in your best interest. Our health professionals will exercise their professional judgment in determining when friends and family members may receive health information (e.g., a family member picking up a prescription from the pharmacy for a sick individual).

Payment. We may use your health information or disclose it to third parties in order to obtain payment for the services that we provide to you. For example, we may discuss your health information with your insurer to determine whether your health plan will cover the treatment

***Research*.** We may use or disclose your health information to third parties for research purposes when an institutional Review Board has determined that such disclosure is appropriate without your permission.

***Treatment*.** We may use your health information or disclose it to third parties to aid with your medical treatment. We may disclose health information about you to doctors, nurses, pharmacist, technicians, medical students, or other persons who are involved in taking care of you. For example, our office may give your health information to your primary physician for follow up services, or to a physician or other healthcare provider for other treatment.

***Health Care Operations*.** We will use and disclose your health information for general administrative and managerial functions, and activities such as quality assessment and improvement, providing educational training programs for medical, nursing, and other health and non-health care professions, accreditation, certification, and licensing. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance, personal decisions, participation in managed care plans, training of students, including imaging of treatment sessions, defense of legal matters, business planning, and outside storage of our records.

***Appointment Reminders and Health Related Benefits and Services*.** We may use and disclose your health information to remind you about appointments for medical care in our offices.

***Marketing*.** We may also engage in face-to-face communication with you about alternative treatment options available to you, or communicate with you about the health related services available to you through our office. We may also give you promotional gifts of nominal value as a method of marketing our services. Before we can use your health information for other marketing purposes or receive payment for sending marketing communications, we must first obtain your written authorization.

As Required By Law. We will disclose your health information to third parties when required to do so by federal, state, or local law. For example, we may share your health information when required to do so by state workers' compensation law, the Department of Health and Human Services, or state regulatory officials**.**

***To Avert A Serious Threat To Health Or Safety*.** We may use and disclose your health information to third parties when it is necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to assist in preventing the potential harm.

***Lawsuits and Disputes*.** If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only after we make efforts to inform you of the request or to obtain an order protecting the requested information. If you are a party to a lawsuit in a Florida court case, either a court order or your authorization must be provided to release your health records in addition to a subpoena.

***Public Policy matters*.** We may use or disclose your health information in certain limited instances for matters involving the public welfare, such as**:**

-For public health risks (e.g., prevention or control of disease, reporting births and deaths, reporting abuse and neglect) or for research purposes when there are sufficient privacy protections in place.

-To a health oversight agency for activities authorized by law (e.g. audits, investigations, inspections, and licensure necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws).

-To law enforcement officials (in response to a court order, subpoena warrant, summons or similar process or to report certain kinds of crimes) and to national security officials under certain limited circumstances.

-To a funeral director, coroner, or medical examiner to permit them to carry out their duties.

-To facilitate organ donation and specified research purposes, so long as certain safety measures are in place to protect your privacy.

***Employers and Plan Sponsors*.** In order for you to be enrolled in a health plan, we may share limited information with your employer or other organizations that help pay for your health coverage. However, if your employer or another organization that helps pay for your health coverage asks for specific health information, we will not share your health information unless they first obtain your written authorization.

***Business Associates*.** We hire third parties to provide us with various services that are necessary for our health plan to function. Before we share your health information with these companies, we will have a written contract with them in which they promise to protect the privacy of your health information.

Fundraising. We may use and disclose your health information for fundraising communications; however, you have the right to opt out of receiving future fundraising communications.

***Other Uses and Disclosures of PHI*.** We have no plans to use or disclose your health information for purposes other than those provided for above or as otherwise permitted or required by law. If you provide us an authorization to use or disclose your health information to third parties, you may revoke the authorization, in writing, at any time. If your revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your written authorization. Please remember that we are unable to take back any disclosures we have already made with your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have several rights regarding your health information and we will respect your right to exercise them. If you wish to exercise your rights, you must submit a written request on a standard form we will provide to you. You can obtain this form by calling the Gulfcoast Vascular Surgeons office at (239) 275-8313, or by writing to us at Gulfcoast Vascular Surgeons 8010 Summerlin Lakes Dr. Suite 100, Ft. Myers FL 33907

***Right to Inspect And Copy*.** You have the right to inspect and copy your health information that we maintain. Usually this includes your medical and billing records. If you request a copy of the information, we may charge a fee for our costs of providing the copy. We may deny your request to inspect and copy in very limited circumstances. If we deny your request to access your health information, we will explain why the request was denied and whether you have the right to a further review of the denial.

***Right to Request Amendments*.** If you feel that your health information is incorrect or incomplete, you may ask us to correct the information. You must include with your request an explanation of how and why your health information needs to be corrected. We may deny your request for correction in certain limited circumstances. If we agree to your request for correction, we will take reasonable steps to inform others of the correction.

Right to Request an Accounting of Disclosures. You have the right to request an accounting of disclosures. This is a list of certain disclosures of your health information that we have made to third parties. This is limited to disclosures of your PHI during the last three years. If you request this accounting more than once in any 12 month period, we may charge you for the cost of responding to these additional requests.

***Right to Request Additional Restrictions*.** You have the right to request a restriction on how we use or disclose your health information to third parties for your medical treatment, payment of your medical claims, or management of our health care operations.

You also have the right to request a limitation on how we disclose your health information to those involved in your care or payment for your care, such as a family member or friend. For instance, you can request that we not disclose information to your spouse or children concerning a sensitive surgical procedure or a disease you have suffered. ***Please note that under federal law, we are generally not required to agree to your request***. However, if you pay the full cost of your treatment without any contribution from a health plan, your health care provider will agree upon your request not to share your treatment with your health plan for payment or health care operation purposes.

***Right to Request Confidential Communications*.** We communicate to you information about your health care treatment and payment. If you feel that our communicating with you may endanger you, you may request that we communicate with you using a reasonable alternative means or location For example, you can ask that we contact you only at work, by e-mail, or by mail at a specified address (such as a Po Box, rather than your home mailing address. We will accommodate all reasonable requests.

***Right to a Paper Copy of This Notic*e.** You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice by writing to us at that address listed below.

Right to receive Notification of a Breach of Your Health Information. You will receive timely notification if there is a breach of your unsecured health information.

CHANGES TO THIS NOTICE

We have the right to change the terms of this Notice. We also have the right to make these changes apply to health information we already have about you, as well as any we receive or create in the future. You can also come in our office and we can have a copy available at your request and take with you. Please look at the front cover of the Notice to determine the Notice's effective date.

QUESTIONS OR COMPLAINTS

If you have questions about your privacy rights described in this Notice, or if you believe that we may have violated your privacy rights, please contact us at:

Gulfcoast Vascular Surgeons
8010 Summerlin Lakes Dr. Suite 100
Ft. Myers FL 33907
(239) 275-8313

You may also file a written complaint with us, as well as with the Department of Health and Human Services. We support your right to protect your health information**.** ***We will not penalize you or retaliate against you for filing a complaint***.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Vascular & Vein Center at Gulfcoast Surgeons' **Notice of Privacy Policies,** and a copy of the **Patient Consent for Use and Disclosure of Protected Health Information,** which detail how my information may be used and disclosed as permitted under federal and state law.

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.

_____ _____
Signature of Patient or Legal Representative Date

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

Relationship to Patient: _____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on: Date: _____Time: _____

Staff Member Name: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Vascular & Vein Center at Gulfcoast Surgeons may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Vascular & Vein Center at Gulfcoast Surgeon's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Vascular & Vein Center at Gulfcoast Surgeons 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 Vascular & Vein Center at Gulfcoast Surgeons at 8010 Summerlin Lakes Drive, Suite 100, Fort Myers, FL 33907.

With my consent Vascular & Vein Center at Gulfcoast Surgeons may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and pathology results among others.

With my consent, Vascular & Vein Center at Gulfcoast Surgeons may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements, laboratory results and pathology results.

I have the right to request that Vascular & Vein Center at Gulfcoast Surgeons restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing the form, I am consenting to Vascular & Vein Center at Gulfcoast Surgeons use and disclosure of my PHI to carry out TPO.

This is a lifetime consent; however, I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. My written revocation must be submitted to Privacy Officer at Vascular & Vein Center at Gulfcoast Surgeons, 8010 Summerlin Lakes Dr., #100, Ft. Myers, FL 33907. If I do not sign this consent, Vascular & Vein Center at Gulfcoast Surgeons may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Representative Date

_____

Print Patient's or Legal Representative's Name

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Please provide the following information:

Preferred Pharmacy Information:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Patient Information CMS requires GCVS to ask:

Primary Language: _____

Race: _____

Ethnicity, please check one of the following:

_____ Hispanic or Latino
_____ Patient Declined
_____ Non- Hispanic or Latino

Patient's Email Address: _____

Email is required for medical record request by the patient only

Please allow us to reconcile your current medications with your pharmacy by signing below

Signature: _____

Print Name: _____

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Patient DOB: _____

_____ I give my permission to Vascular & Vein Center at Gulfcoast Surgeons to disclose my protected health information and patient medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have Power of Attorney on behalf of myself.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

OR

_____I request that all my Protected Health Information and/or Medical Record Information be disclosed to **ME ONLY.** In addition, the patient agrees that Vascular & Vein Center at Gulfcoast Surgeons may disclose the following type of information contained in the patient's medical records to carry out any treatment, payment and healthcare operations.

(Please initial the appropriate categories that you choose to disclose listed below):

_____HIV/AIDS information

_____Mental Health Information

_____Substance Abuse Information

May we leave test results on any of the following: (Please initial the device(s) of your choice)

_____Home Answering Machine

_____Cellular Phone Voicemail

_____Work Voicemail or Answering Machine

At all times, patient retains the right to revoke this consent. Such revocation must be submitted to Vascular and Vein Center at Gulfcoast Surgeons in writing.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____ Date: _____

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FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to understand our financial policies to avoid any future misunderstandings.

Insurance - You are financially responsible for all charges unless a contract between us and your insurance company prohibits us from billing you. As a service to you, we will file your insurance claim if you assign the benefits to us so that your insurance company can pay us directly. We will also follow up for you, but if your insurance company does not pay the claim within a reasonable period, then you may be responsible for the payment.

Self-pay - If you do not have insurance, or if we cannot verify your coverage, payment is due at the time of service.

Benefit Verification – We will contact your insurance carrier to verify your benefits when necessary or when you request us to do so. We do this so that you will have an estimate of what your financial responsibility will be, and to determine what portion of your charges should be paid by you at or before the time of service. When we contact your insurance carrier, we are told that benefits given are not a guarantee of payment. Therefore, when your claim is actually processed by your insurance company, it is possible that your portion of the charges could be different from what we and you were told when we verified your coverage. We cannot guarantee what your insurance company will pay. Therefore, you may receive a bill from us if the insurance company denies, changes, or reduces the payment for the services we provided. **Benefit verification is an estimate, not a guarantee of your insurance benefits.**

Co-payments & Deductibles – When your insurance specifies a co-payment and/or when you have a deductible remaining, these payments are due at the time of service.

Prior Authorization – Some Health Maintenance Organizations (HMOs) and Independent Physician Associations (IPAs) require you to obtain a referral for our services from your primary care provider. We will attempt to determine if you need to have this referral before you visit our office. Please contact your insurance or your primary care provider if you have questions about the need for a referral.

Returned checks – We will charge a fee of $35.00 for unpaid, returned checks.

Credit Cards – We accept Visa, MasterCard, Discover and American Express.

Collection Agency – If your account is delinquent we may file it with a collection agency to collect payment. If this becomes necessary, your account may be charged additional fees to offset some of the collection costs we incur.

Missed Appointments – We charge $35.00 for missed office visits, $50.00 for missed lab visits, $250.00 for missed Endovenous Ablation of the Vein, and $500.00 for any missed procedures in our Angio suite. You must cancel your appointment 48 hours in advance to avoid these charges.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party, if minor) Date

_____

Please print the name of the patient