Alabama Heart & Vascular Medicine

New Patient Information Form

DATE:_____ ACCT NUMBER: _____

Patient Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Age: _____ Marital Status: Married/Single/Widowed/Divorced

Mailing Address: _____
(Street) (City) (Zip Code)

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email:_____ Male/Female Social Security No: _____

Did another physician refer you here? Y/N Referring Physician: _____

Who is your family physician: _____

Language: English/Spanish/Other Race: _____ Ethnicity: _____

Employed: Yes/No/Retired Employer: _____

Pharmacy Name:_____ Phone No: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____
Contract Number: _____ Group Number: _____
Insured's Name: _____ Insured's DOB: _____

Patient's relation to insured party: Self/Spouse/Parent/Child/Other Male/Female

Secondary Insurance Name: _____ Effective Date: _____
Contract Number: _____ Group Number: _____
Insured's Name: _____ Insured's DOB: _____

Patient's relation to insured party: Self/Spouse/Parent/Child/Other Male/Female

Please have your Driver's License and all Insurance Cards available for us to scan. Thank you.

Who can we contact in case of an emergency?
Name: _____ Phone: _____ Relation: _____

I hereby authorize Alabama Heart & Vascular Medicine to release any medical information needed by my insurance carriers in order to process my claim. I hereby authorize payments direct to Alabama Heart & Vascular Medicine. I understand that it is my responsibility to provide correct insurance information to Alabama Heart & Vascular Medicine. **I understand that my insurance may not pay the bill and that some services may be considered "noncovered or not medically necessary" by my insurance contract. I understand that I will be responsible for the balance of my account.**

_____ Date: _____ _____ Date:_____
Patient's Signature (Agreement to Pay) Guarantor's Signature (Agreement to Pay)

Alabama Heart & Vascular Medicine

Consent to Release Information

I (the patient or responsible party) hereby authorize Alabama Heart & Vascular Medicine, it's physicians, agents, employees, or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person(s) listed below.

_____Spouse Name: _____

_____Parent(s) Name(s): _____

_____Child/Children Name(s): _____

_____Other: Name(s): _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Alabama Heart & Vascular Medicine's Notice of Privacy Practices.

_____

Please Print Name

_____ _____

Patient or Responsible Party Signature Date Signed

Alabama Heart and Vascular Medicine
Authorization to Release or to Obtain Medical Information
Fax (205) 345-4921

Patient Name (print): _____ DOB: _____/_____/_____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

I, the undersigned, authorize and request **Alabama Heart and Vascular Medicine to ____ release or to ____ obtain medical information from the following:**
Physician/Organization/Individual(s): _____
Address: _____Phone:_____ Fax: _____

_____ DCH Regional Medical Center or Northport Medical Center, 809 University Blvd., Tuscaloosa or 2700 Hospital Drive, Northport, AL, 205-759-7111 or 205-333-4500
Or other Hospital(s):_____
Address: _____ Phone:_____ Fax: _____

Please identify the information to be released/obtained:
___ Complete Record
___ *Lab Results (specify)* _____
___ *X-Ray/Imaging (specify)* _____
___ *Other (specify)* _____

The identified information will be used for the following purposes:
____ Sharing with my other healthcare providers
____ *For my personal records*
____ *Moving*
____ *Other (specify)* _____

Please initial each item below to indicate your understanding:

_____ I understand the information in my health record may include information relating to STD's, AIDS, or HIV. It may also include information relating to behavioral or mental health services, and treatment for drug and alcohol abuse.

_____ When my information is used or disclosed pursuant this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization at any time in writing and understand my revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

Patient Signature: _____ Date: _____/_____/_____

Relationship to Patient: _____ Parent, _____ Legal Guardian, ____ Other (please specifiy) _____

Witness Signature: _____ Date: _____/_____/_____

This authorization will expire on (insert date or event): _____
If I do not specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Patient Name:_____Date of Birth:_____Date: _____

Please check and add details out to the side

PAST MEDICAL HISTORY

- ☐ Anemia
- ☐ Asthma
- ☐ Aneurysm: abdominal
- ☐ Aneurysm: Thoracic
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Atrial Flutter
- ☐ Coronary Artery Disease
- ☐ Cancer
- ☐ Cellulitis
- ☐ Claudication
- ☐ Congestive Heart Failure
- ☐ Connective Tissue Disease (Lupus, Sarcoidosis, etc.)
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ CVA/Stroke
- ☐ Deep Vein Thrombosis
- ☐ Diabetes (insulin or non-insulin dependent
- ☐ Dialysis
- ☐ Endocarditis
- ☐ Gastrointestinal Bleed
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Heart block
- ☐ Hypertension
- ☐ Lipid disorder
- ☐ Liver disease
- ☐ Murmur
- ☐ Irregular heart rhythm
- ☐ MVP (mitral valve prolapse)
- ☐ PAH (Pulmonary Artery Hypertension)
- ☐ Phlebitis
- ☐ Pleurisy
- ☐ PUD (peptic ulcer disease)
- ☐ Pulmonary Embolism
- ☐ PVD (peripheral vascular disease)
- ☐ Renal Failure
- ☐ Renal Insufficiency
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Seizure Disorder
- ☐ SVT (supraventricular tachycardia)
- ☐ Syncope
- ☐ TB (tuberculosis)
- ☐ Thyroid disorder
- ☐ TIA (transient ischemic attack)
- ☐ Valvular Heart Disease
- ☐ Ventricular Tachycardia
- ☐ Other: _____

SURGICAL HISTORY

Please check and list dates/facility/surgeon

- ☐ Abdominal surgery _____
- ☐ Amputation: above knee
- ☐ Amputation: below knee
- ☐ Anesthesia problems
- ☐ Aneurysm Repair
- ☐ Aortic Valve Repair
- ☐ Aortic Valve Replacement
- ☐ Appendectomy
- ☐ Arteriogram:____Carotid_____Legs_____Kidneys
- ☐ Bypass: Aorta-femoral:____left_____right
- ☐ Bypass: Fem-pop____left_____right
- ☐ CABG (open heart)
- ☐ Congenital heart surgery
- ☐ Endarterectomy_____Lt carotid_____Rt carotid
- ☐ EPS (Electrophysiology Study)
- ☐ MI (heart attack)
- ☐ Gallbladder surgery
- ☐ Heart cath (dye test)
- ☐ ICD (Defibrillator)
- ☐ ICD: BI-V
- ☐ Mitral Valve Repair
- ☐ Mitral Valve Replacement
- ☐ Pacemaker
- ☐ PTCA/Angioplasty/stent) heart
- ☐ PTCA (Angioplasty/stent) leg_____Kidney
- ☐ Stent:____Aorta_____Carotid_____Iliac
- ☐ Surgical Complications
- ☐ Thyroid Surgery
- ☐ Other operations:

_____

_____

_____

Patient Name:_____ Date: _____

Home Medications:
List all medications & dosage you are presently taking and how frequently you take them:

Medication/Dose/Frequency:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all known allergies:

_____
_____

_____

FAMILY HISTORY

Please check box and circle the family member

- ☐ Aortic Aneurysm [father, mother, sibling, grandparent]
- ☐ Asthma [father, mother, sibling, grandparent]
- ☐ Bleeding Disorder [father, mother, sibling, grandparent]
- ☐ Cancer _____ [father, mother, sibling, grandparent]

- ☐ Congestive Heart Failure [father, mother, sibling, grandparent]
- ☐ Connective Tissue Disease [father, mother, sibling, grandparent]
- ☐ Coronary Artery Disease [father, mother, sibling, grandparent]
- ☐ Coronary Heart Disease – male < 55 [father, mother, sibling, grandparent]
- ☐ Coronary Heart disease – female < 55 [father, mother, sibling, grandparent]
- ☐ CVA or stroke [father, mother, sibling, grandparent]
- ☐ Diabetes [father, mother, sibling, grandparent]
- ☐ Hyperlipidemia [father, mother, sibling, grandparent]
- ☐ Hypertension [father, mother, sibling, grandparent]
- ☐ Marfan's Syndrome [father, mother, sibling, grandparent]
- ☐ Pulmonary Artery Hypertension [father, mother, sibling, grandparent]
- ☐ Peripheral vascular disease [father, mother, sibling, grandparent]
- ☐ Prolonged QT [father, mother, sibling, grandparent]
- ☐ Renal Disease [father, mother, sibling, grandparent]
- ☐ Sudden Cardiac Death [father, mother, sibling, grandparent]
- ☐ Thyroid Disease [father, mother, sibling, grandparent]

Mother living? Yes No Age at death_____Father living? Yes No
Age at death_____Number of living brother & sisters_____Number of deceased brothers & sisters _____

SOCIAL HISTORY

Marital Status: Single/Married/Divorced/Widowed
How many children do you have? _____
What is your occupation: _____
Disabled Retired

Smoking History:

Current Smoker: year started _____
Cigarettes:_____packs per day
Cigars:_____number per day
Smokeless:_____amount per day
Counseled to quit or cut down: Yes No
Former Smoker: year quit _____

Never smoked:

Passive smoke exposure: Yes No
Do you drink alcoholic beverages? Yes No
Types of Alcohol? _____
How many drinks per day? _____

Drug Use? Yes No (If yes circle type below)
Marijuana, cocaine, crack, heroin, illicit prescription
Other: _____

Do you drink caffeinated drinks? Yes No
How many per day? _____
Do you drink diet drinks? Yes No

Are you on a special diet? Yes No
Calorie Limited Low Salt
Low Fat Diabetic
High Fiber Low Cholesterol
Other _____

Do you exercise on a regular basis? Yes No
How many times per week? _____
Type of exercise? _____

Do you have a barrier to communication? Yes No

High Risk Behavior? Yes No
Comments: _____

Patient Name:_____Date of Birth:_____Date: _____

Review of Systems (please check if you have any of the following)

General

- ☐ Daytime sleepiness
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Cardiovascular

- ☐ Chest pain
- ☐ Fainting
- ☐ Heart racing (palpitations)
- ☐ Swelling in feet/legs (peripheral)

Respiratory

- ☐ Cough
- ☐ Excessive snoring
- ☐ Shortness of breath
- ☐ Wheezing

Neurologic

- ☐ Dizziness (lightheadedness)
- ☐ Morning headaches

Gastro-Intestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Indigestion
- ☐ Dark tarry stools
- ☐ Nausea/Vomiting

Genital-Urinary

- ☐ Difficult urination (dysuria
- ☐ Blood in urine (hematuria)

Musculo-Skeletal

- ☐ Leg pain
- ☐ Muscle cramps

Dermatologic

- ☐ Non-healing ulcer
- ☐ Scar to chest
- ☐ Scar to leg

Ears, Nose, Throat

- ☐ Hoarseness
- ☐ Nosebleed

Psychiatric

- ☐ Anxiety
- ☐ Depression

Allergies

- ☐ Allergic to Iodine
- ☐ Allergic to medications
- ☐ Allergic to shellfish
- ☐ Allergic to dye

Form Completed by: _____

Patient Name:_____Date of Birth:_____Date: _____

Vascular Screening

History

Varicose veins are large, bulging veins, as opposed to spider veins, which are thin, branching veins just beneaththe skin's surface. Have you ever had varicose veins? _____

Signs and Symptoms

Do you experience any of the following signs and symptoms in your legs or ankles?

Leg pain, aching or cramping_____

Burning or itching of the skin_____

Leg or ankle swelling, especially at the end ofthe day_____

A feeling of heaviness in legs____

Pain from prolonged sitting or standing _____

Skin discoloration or texture changes, such asabove the inner ankle_____

Open wounds or sores, such as above the innerankle_____

Restless legs_____

Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed withchronic venous insufficiency or venous reflux? Yes_____ No_____

Have you had a blood clot in a vein that cause inflammation, pain, or irritation? Yes_____ No_____

Do you have ropey veins or veins that are raised above the skin in your legs? Yes_____ No_____

Have you had any treatments or procedures for vein problems? Yes_____ No_____

Do you stand for long periods of time, such as at work? Yes_____ No_____

Do you suffer from tingling, numbness, burning or cramping in legs or feet? Yes_____ No_____

Do you frequently engage in heavy lifting? Yes_____ No_____

Do you have skin discoloration on your lower legs? Yes_____ No_____

Do you have hard to heal ulcers or sores on your lower legs? Yes_____ No_____

If female, have you ever been pregnant? Yes_____ No_____

ALABAMA HEART & VASCULAR MEDICINE

PHONE MESSAGE CONSENT FORM

Your physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:

- LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.
- LEAVE INFORMATION ON AN ANSWERING MACHINE
- LEAVE INFORMATION ON A VOICEMAIL

Please read below and consider carefully whom you want to have access to your medical information.

I_____give Alabama Heart & Vascular Medicine my permission to leave phones messages regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

My cell phones: (_____)_____-_____ initials:_____

My home answering machine/voicemail: (_____)_____-_____ initials:_____

My office/work voicemail: (_____)_____-_____ initials: _____

My medical care may be discussed with the following:

My spouse:_____at (_____)_____-_____ initials:_____

Other:_____at (_____)_____-_____ initials: _____

☐ **I DO NOT WANT MY INFORMATION LEFT ON VOICEMAIL**

_____ _____

Patient/Guardian Signature Date

Alabama Heart & Vascular Medicine

No Show Policy

Due to the negative impact that NO SHOWS have on our schedule we have developed a no-show policy. To better serve you and our other patients we now require a minimum notice for cancellations. By signing this document, you are acknowledging that you understand and agree to our advance notice policy and the applicable NO SHOW fee associated.

24-Hour Notice Required for:
Office visit no-show fee of $50
Nuclear stress test no-show fee of $250

48-Hour Notice Required for:
Procedure no-show fee of $500

If you fail to notify our office prior to your visit your account will be charged the applicable no-show fee and you will be responsible for paying the charge prior to rescheduling.

If you miss three appointments within one year, you will be subject to dismissal from the practice.

**The only exception to this policy will be made in case of a true emergency. **

Thank you!

Patient Name: _____

Patient Signature: _____Date:_____

Alabama Heart & Vascular Medicine

Photo Policy

I consent that a statement/interview, and/or photograph, and/or illustration, and/or video, and/or audio recording may be taken of me by Bama Heart Doc, P.C., d/b/a Alabama Heart and Vascular Medicine ("Alabama Heart & Vascular Medicine") regarding my personal and medical history, condition(s), and treatment(s) for the purposes of documentation, education, publication, promotion, marketing, or advertising activities, programs, and services.

I consent and grant permission to Alabama Heart and Vascular Medicine to the use of any such statement/interview, and/or photograph, and/or illustration, and/or video, and/or audio recording, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, which may include Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPPA), by Alabama Heart & Vascular Medicine for any lawful use Alabama Heart and Vascular Medicine deems appropriate, including for treatment, advertising his/her/its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational, promotional, advertising, or marketing purposes. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Alabama Heart and Vascular Medicine. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Alabama Heart and Vascular Medicine will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the extent possible. I understand that Alabama Heart and Vascular Medicine cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Alabama Heart and Vascular Medicine may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my age, and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Alabama Heart and Vascular Medicine may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness. I have read the foregoing in its entirety and understand its terms.

_____ _____

Print Patient Name Signature of Patient

_____

Date

Appointments:

Scheduling an Appointment:

Please call our office to schedule an appointment: (205) 561-2370

When scheduling an appointment all callers are required to provide us with the name and birth date of the patient along with a short description of the problem for which they are to be seen. We will call to remind you of your upcoming appointment.

Please bring your medications to each office visit for clarification.

Cancellations:

If you need to cancel your appointment please do so within 24 hours of the appointments scheduled time. This is a reasonable amount of time- designed to give other patients in need the opportunity to schedule during that time frame. Failure to cancel your appointment within a reasonable amount of time may result in a $50 no show fee.

The Day of your Appointment:

Please check-in with the receptionist 5-10 minutes prior to your appointment to give yourself enough time for registration. *Please do not show up any earlier as it will only extend the time you wait to be seen.* If you are more than 15 minutes late for your appointment, you may be asked to reschedule so that we may honor the appointment time of our other patients.

If you are an established patient (someone seen by our practice in the past three years), you will be asked to verify your address, phone number, and insurance information by signing your billing form. If you are a new patient, you will be asked to fill out all of the "new patient" paperwork. If you fill out your "new patient" paperwork ahead of time- and turn it in prior to your office visit- it will decrease your office visit by 20-30 minutes (time needed to create your patient chart)

We will update all patient information every year in accordance with federal regulations, insurance requirements, and as needed. As a result, you will be asked to review and update certain information upon arrival to your appointment. Your cooperation with our process is greatly appreciated. Regardless if you are a new patient or an established patient you should always bring your current insurance information and a government form of identification (parents of minors may be asked for their identification) to all of your office visits.

Because we know your time is valuable, we make every effort to honor your appointment time and recognize the inconvenience of unexpected waiting periods. The average time you should expect for an office visit ranges from 45 minutes to 1 hour and 30 minutes. This is due to the time it takes for the nurse to check you in, update your chart; vital signs and pertinent information to be updated; and all your concerns to be addressed by the provider.

problem and begin any needed emergency treatment. The Emergency department physician will contact our cardiologist on call for any needed help in your care.

After hours:

We have a physician on call, for urgent or emergent issues only. Please call the office and select option 1 to be connected to them.

Medical emergencies include; but are not limited to: *Chest pain or pressure, difficulty breathing, high blood pressure > 180/100; dizziness or passing out; low blood pressure < 90/60 that is making you dizzy or causing symptoms of discomfort. ..*

Calls for routine questions and prescription refills should be made during office hours ONLY. Prescriptions WILL NOT be refilled after-hours. The physician on call needs access to your medical records for these types of questions/needs and will NOT have access to this information after hours.

If your phone has 'anonymous call rejection' please deactivate this feature so the physician can call you back.

Testing:

Expected time for each test:

6 minute walk test: 20 minutes

Ankle to Brachial Index: 15 minutes

Aorta Duplex scan: 45 minutes

Carotid Duplex scan: 45 minutes

Echocardiogram : 1 hour

Electrocardiogram (EKG or ECG): 15 minutes

Event monitor: 3-4 weeks

Graded Exercise Test (GXT) : 1 hour

Groin duplex scan: 15 minutes

Nuclear Stress test: 3-4 hours

Peripheral Venous/Arterial Duplex Scan: 45 minutes

Stress echocardiogram (exercise): 1 hour

Test results:

There are three main reasons a doctor might order tests for you. One reason would be to diagnose you. The second reason would be to measure the effectiveness of a treatment. The third reason would be to monitor a chronic illness or condition.

You will be notified of all your test results: normal or not normal- every time. The results of your tests will be called to you by our staff in a timely manner. Copies of your testing are given to you at the time of your next appointment. If you have not heard from us within 2 weeks of your testing- Please call.

- As we know stress testing/nuclear stress testing causes great anxiety: the usual time for this test to be processed is typically 3-5 days. If your test is positive- you will be brought back into the office the next week to meet with your Doctor to discuss the results and options. Your result will be called to you whether it is positive or negative.

If your test results are complicated or require follow up, then they should always be reported in person. You want the professional who has some of the answers for you sitting across from you when that news is delivered. You probably want someone you love next to you, too, and that likely wouldn't happen on a phone call either.

If your test results are complicated or require follow-up then they should be reported in person, too. For example, if we order an echocardiogram to follow up (monitor an known or existing problem) on a 'leaky valve' or 'to check how your heart is pumping'. It's not necessarily bad news because you may already know about it. But you'll need follow up in the form of new details: explanations of your treatment options, getting a referral and appointment for your treatment choice, explanation of any new procedures needed and more.

If your test results show that no follow up is required (maybe they are good news, or perhaps they are your standard answers - nothing has changed), then they can be reported by phone, email, by your online access to your own medical record, or even by postal mail. They should not require a follow up visit to the doctor's office. Examples of this type of testing might be regular cholesterol check which hasn't become problematic since the last one.

Some doctors will tell you they cannot deliver test results by phone because they could be in violation of HIPAA privacy laws. This is not true - We can talk to the patient on the phone and provide all the necessary information as long as they are sure that it is the patient they are talking to. We can also leave a message on an answering machine requesting the patient return their call, at which time they can deliver test results on the phone. Actual test results cannot be left on an answering machine. They can only be given directly to the patient.

Co-payments, deductibles, and time of service payments –

Co-pays:

Insurance companies will often require their patients to pay a "co-pay" for their office visits. The amount of your co-pay may or may not be listed on your insurance card. All co-pays required by your insurance company will be collected upon your arrival at check-in. Co-pays are expected to be paid the day of service.

Deductibles:

Now more than ever, deductibles have become a part of family and/or individual insurance plans. Your deductible is considered to be your out-of-pocket expense that must be paid by you before your insurance company will cover your medical expenses. Deductibles in healthcare can range anywhere from $100 to $10,000. It is always the policy holder's (patient's) responsibility to know their insurance plan and the amount of their deductible.

If you have not met your deductible and receive a service (i.e. echocardiogram; stress test) our billing department will mail you the balance due to be paid. Statements for our services are mailed monthly. You will be responsible for any co-pay; deductible and non-covered services.

Please contact us if you have any questions regarding your account.

Insurance:

We accept assignment and participate with the following payers:

Blue Cross/Blue Shield of Alabama PMD, Medicare, Medicaid, Champus, Phifer Wire, UMWA,AETNA, United Healthcare, Guidestar, Medicare Advantage products (such as Blue Advantage)

And, most other insurance companies

Patients who do not have insurance are required to pay $300 on the first visit. Any further services can be set up on a payment plan.

Collections:

The patient understands that if they do not pay their bill when due that the office will turn them over to collections and pass the 28% collection agency fee on to the patient.

Patient Signature: _____ Date: _____

Prescription Refill Policy:

We prefer to refill your medications at the time of your office visit and will provide enoush to last until your next office visit. Please bring your medicine bottles and/or a detailed 11st of your current medications with you to each appointment. Patients must have been seen by Alabama Heart and Vascular Medicine within the past year for us to refill your prescription.

Refill requests are handled during normal office hours only. Call your pharmacy if you need a refill; your pharmacist is in the best position to safely and accurately coordinate the request with our staff. Your prescription will be refilled within 24-48 hours (throush the pharmacist).However, we do provide a phone/voicemail line to take requests. Please allow at least 48 hours for all prescription refill requests. This is Option 0 on the main menu. If the line is busy, you will be prompted to provide the following information: *1.Name 2.Date of birth 3.Pharmacy name 4.Medication 5.Phone number where you can be reached*

We can only refill prescriptions that our healthcare providers have originally written. If you are seeking a refill on a prescription that was not written by Alabama Heart and Vascular Medicine you will need to make an appointment so our providers can review your medical need. This is a safety and legally required action.

Please try to anticipate your need for prescription refills, as we are reluctant to authorize refills or changes after our usual office hours when your medical record is not readily available. Should you need your cardiac medications over a weekend, our physician on call will prescribe only enough medication to last until next business day. Please do not call for refills on controlled substances (narcotics) . We do not prescribe them. This should be addressed with your primary care provider.

If you use a mail order pharmacy, we will send a facsimile directly to your mail order company from our electronic medical records system or, if requested, we can print and mail prescriptions directly to the patient to order.

We understand the high cost of medication prescriptions and we will try to provide alternative options when necessary. Samples of prescribed medications are occasionally available and are distributed as per your doctor's instructions.

Calling our office

Telephone calls during hours: We would like you to follow all policies and procedures very closely to make both your time and our time efficient and avoid any errors. A nurse will return all calls received before 4:00 pm; by the end of the day. Any calls after 4pm will be addressed on the next business day.

Our phones are answered by our staff from 8:00 to 4:30 pm. Our trained staff accepts all calls from patients, enabling the Doctor to spend more time with the patients in the office. IF it is a routine question, your call will be transferred to the nurse call line.

It is difficult to say how soon we will get back to you as it depends on the number of patients we are seeing. Please do not call more than one time as it only slows our system down. You will be called back the same day.

Urgent Problems: If you develop an urgent problem other than an emergency, please call our office Monday to Thursday between 8:00 A.M. and 4:00 P.M or Friday 8:00 A.M. to 12:00 Noon. Your cardiologist or nurse practitioner will review your problem and medical record. A nurse will call you back with your physician's instructions. After hours, your urgent calls will be forwarded to our cardiologist on call.

Emergencies: If you develop an emergency problem, please go to your nearest hospital emergency room or dial 911. In the Tuscaloosa area, use DCH Regional Medical Center Emergency Department. Identify yourself as one of our patients and request that the Emergency Department physician evaluate your condition.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to the information.

Please Review It Carefully.

Alabama Heart and Vascular Medicine (hereafter referred to as AHVM) is required by federal law to maintain the privacy of your individually identifiable health information and to provide you with notice of our legal duties and privacy practices. We will no use, release, or disclose your health information except as specifically described in this Notice of Privacy Practices, unless specifically authorized by you in writing. In providing professional medical services to you, we will create, maintain, and store your protected health information. This Privacy Notice applies to protected health information included as a part of your medical records generated by AHVM.

Examples of Disclosures for Treatment, Payment and Health Operations:

The following categories describe the ways that we may use, release, and disclose your health information for treatment, payment, and health care operations *without the need* for an additional and specific signed authorization from you.

Personal Information: We store your personal information in our EMR computer system which is in compliance with HIPPA guidelines. We protect your information using physical, technical, and administrative security measures to reduce the risks of loss, misuse, unauthorized access, disclosure and alteration. Some of the safeguards we use are firewalls and data encryption, physical access controls to our data centers, and information access authorization controls.

Treatment: We will use your protected health information in the provision and coordination of your health care. For example, we may disclose all or any portion of your medical record information as part of your care and continued treatment to your attending physician, consulting phyisician(s), nurses, technicians, and other health care providers who have a *legitimate* need for such information.

Family/Friends: We may release protected health information about you to a friend or a family member *who is involved* in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends of your condition and that you are at AHVM.

Payment: AVHM may release protected health information about you for the purpose of determining coverage, billing, claims management, medical data processing, and reimbursement. For example, the information may be released to an insurance company, third party payer, or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medicl record, which are *necessary* for the payment of your account.

Routine Healthcare Operations: AHVM may use and disclose your protected health information during routine healthcare operations. These operations may include quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activites, management and administration of AHVM, and education purposes.

Appointment Reminders: AHVM may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment, medical care, or follow-up at AHVM and may leave a message for you at a number that AHVM has listed for you.

Health Related Business, Services, and Treatment Alternatives: AHVM may use and disclose your protected health information to tell you of health-related benefits or services provided by AHVM that may be of interest to you and your particular medical condition.

Regulatory Agencies: AHVM may disclose your medical information to a health oversight agency for activities authorized by law including, but not limited to, licensure, certification, audits, investigations, and inspections.

Law Enforcement/Litigation: AHVM may disclose your medical information to a law enforcement official for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Public Health: As required by law, AHVM may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Serious Threat to Health or Safety: AHVM may use and disclose protected health information when necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. Disclosures will only be made to a person or organization able to prevent the threat.

Military/Veterans/National Security: AHVM may disclose your medical information as required by military command authorities, if you are a member of the armed forces. In addition, AHVM may disclose your medical information to federal officials for intelligence and national security activities authorized by law.

Required by Law: AHVM will disclose medical information about you when required to do so by law.

Coroners, Medical Examiners, and Funeral Directors: AHVM may release your medical information to a coroner, medical examiner, or to funeral directors as necessary to carry out their duties.

Business Associates: AHVM may use and disclose certain medical information about you to business associates of AHVM. A business associate is an individual or entity under contract with AHVM to perform or assist AHVM in a function or activity, which requires the use or disclosure of medical information. The law also requires AHVM to obtain reasonable, written assurances from its business associates that they will also protect the confidentiality of your medical information.

Research: AHVM may use or disclose your medical information for research purposes in certain limited circumstances.

Workers Compensation: AHVM may be required under law to release medical information about you for worker's compensation or similar programs.

Inmates: If you are an inmate of a correctional facility or under the custody of a law enforcement officer, AHVM may release your medical record information to the correctional facility or law enforcement official.

Your Individual Rights:

You have the following rights concerning your medical information.

Right to Confidential Communications: You have the right to request that AHVM communicate with you about your health and related issues in a particular manner or at a certain location. AHVM will accommodate *reasonable* requests.

Right to Inspect and Copy: You have the right to inspect and copy your medical information, including patient medical records and billing information. Consistent with federal law, AHVM may deny access to certain medical information most notably, psychotherapy notes. A reasonable cost-based charge for copying, labor, mailing, and supplies may be assessed. If a summary of the medical records is requested, a fee may be assessed, as well. In certain limited circumstances, AHVM may deny your request to inspect and copy; however, you may request a review of your denial.

Right to Amend: You have the right to amend your medical record information if your believe it to be incorrect, inaccurate, or incomplete as long as the information is created by, kept, and maintained by or for our medical practice. You must request an amendment in writing and include the reasons supporting your request for amendment. AHVM, however, may not agree to honor your request for an amendment.

Right to an Accounting: You have the right to obtain a statement or an "accounting" of AHVM's use or disclosure of your protected health information. A request for an accounting must be made in writing.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your medical information. AHVM may not agree to honor your request for restrictions; however, if we do agree, we are bound by our agreement except

when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Right to Receive Copy of this Notice: You have the right to receive a paper copy of this Notice, upon request.

Right to Revoke Authorization: You have the right to revoke any authorization allowing AHVM to use or disclose your medical information except to the extent that action havs already been taken by AHVM in reliance upon that authorization.

Please note that to exercise any of the privacy rights described herein, you must complete a written request and send it to Privacy Officer at Alabama Heart and Vascular Medicine. AHVM will carefully review each patient request and respond within thirty (30) days.

If you have problem or would like to request more information, you may contact the Privacy Officer at Alabama Heart and Vascular Medicine at (205) 561-2370.

If your believe your privacy rights have been violated, you may file a complaint with AHVM or with the Office of Civil Rights.
To file a complaint with AHVM, please contact:
Alabama Heart and Vascular Medicine
Attn: Privacy Officer
100 Rice Mine Road Loop Suite 104
Tuscaloosa, AL 35406
For complaints involving covered entities located in Alabama:
Region IV, Office for Civil Rights
US Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street SW
Atlanta, GA 30303-8909
Voice Phone: (404) 562-7886
Fax: (404) 562-7881
TDD: (404) 331-2867

All complaints must be submitted in writing.

There will be NO retaliation for filing a complaint or expressing a concern.

Changes to this Notice: AHVM will abide by the terms of the Notice currently in effect. AHVM reserves the right to change the terms of its Privacy Notice and to make the new Notice provisions effective for all individually identifiable health information that it maintains.

Privacy Notice Effective Date: The effective date of the Privacy Notice is April 1, 2012.