

# 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.**

\_\_\_\_\_  
Patient's Signature (Agreement to Pay) Date: \_\_\_\_\_

\_\_\_\_\_  
Guarantor's Signature (Agreement to Pay) Date: \_\_\_\_\_

# 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. A copy can also be found in the lobby and our on website.

\_\_\_\_\_  
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 specify) \_\_\_\_\_

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**

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

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**SURGICAL HISTORY**

Please check and list dates/facility/surgeon

- |  |   |
|--|---|
| <input type="checkbox"/> Abdominal surgery _____                   | <input type="checkbox"/> Gallbladder surgery                    |
| <input type="checkbox"/> Amputation: above knee                    | <input type="checkbox"/> Heart cath (dye test)                  |
| <input type="checkbox"/> Amputation: below knee                    | <input type="checkbox"/> ICD (Defibrillator)                    |
| <input type="checkbox"/> Anesthesia problems                       | <input type="checkbox"/> ICD: BI-V                              |
| <input type="checkbox"/> Aneurysm Repair                           | <input type="checkbox"/> Mitral Valve Repair                    |
| <input type="checkbox"/> Aortic Valve Repair                       | <input type="checkbox"/> Mitral Valve Replacement               |
| <input type="checkbox"/> Aortic Valve Replacement                  | <input type="checkbox"/> Pacemaker                              |
| <input type="checkbox"/> Appendectomy                              | <input type="checkbox"/> PTCA/Angioplasty/stent) heart          |
| <input type="checkbox"/> Arteriogram: ___Carotid___Legs___Kidneys  | <input type="checkbox"/> PTCA (Angioplasty/stent) leg ___Kidney |
| <input type="checkbox"/> Bypass: Aorta-femoral: ___left___right    | <input type="checkbox"/> Stent: ___Aorta___Carotid___Iliac      |
| <input type="checkbox"/> Bypass: Fem-pop ___left___right           | <input type="checkbox"/> Surgical Complications                 |
| <input type="checkbox"/> CABG (open heart)                         | <input type="checkbox"/> Thyroid Surgery                        |
| <input type="checkbox"/> Congenital heart surgery                  | <input type="checkbox"/> Other operations:                      |
| <input type="checkbox"/> Endarterectomy ___Lt carotid___Rt carotid | _____   |
| <input type="checkbox"/> EPS (Electrophysiology Study)             | _____   |
| <input type="checkbox"/> MI (heart attack)                         | _____   |

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 beneath the 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 of the day \_\_\_\_\_

A feeling of heaviness in legs \_\_\_\_\_

Pain from prolonged sitting or standing \_\_\_\_\_

Skin discoloration or texture changes, such as above the inner ankle \_\_\_\_\_

Open wounds or sores, such as above the inner ankle \_\_\_\_\_

Restless legs \_\_\_\_\_

### Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed with chronic 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 \_\_\_\_\_

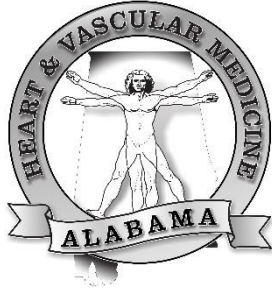
Do you suffer from tingling, numbness, burning or cramping in legs or feet? Yes \_\_\_\_\_ No \_\_\_\_\_

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

At times, we will need to contact you by phone.

Please indicate which phone number(s) we may leave a message at regarding your results.

\_\_\_\_\_ Cellphone (number: \_\_\_\_\_ )

\_\_\_\_\_ Home Phone (number: \_\_\_\_\_ )

\_\_\_\_\_ Work Phone (number: \_\_\_\_\_ )

My medical care may be discussed with the following:

\_\_\_\_\_ Spouse (name: \_\_\_\_\_ )

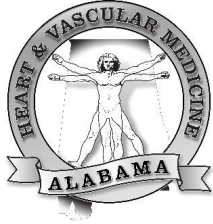
\_\_\_\_\_ Children (names: \_\_\_\_\_ )

\_\_\_\_\_ Other (name: \_\_\_\_\_ )

**By signing this form, I am consenting to results being left on my voicemail, answering machine, or being sent via text message.**

\_\_\_\_\_  
Patient 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 (HIPAA), 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

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Signature of Patient

---

Date

## 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 not 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 physician(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:** AHVM 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 medical 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 activities, 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 you 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 has 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 you 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.

# Alabama Heart and Vascular Medicine

100 Rice Mine Road Loop, Suite 104  
Tuscaloosa, Alabama 35406  
Phone: (205) 561-2370 Fax: (205) 345-4921

## Office Policy and Procedures

### Medical Staff

**G. Phil Hemstreet, M.D.**

General Cardiology, Interventional Cardiology, Structural Heart Disease;

**Dana Hemstreet, CRNP**  
**McKenzie Cunningham, CRNP**  
**Kelly Hall, CRNP**

Vascular Medicine. Specializing in Percutaneous Coronary Interventions; Peripheral Vascular Disease Treatment and Intervention; Advanced Lipid Management; Hypertension

Certified Registered Family Nurse Practitioners specializing in Cardiovascular Medicine

### Hours of Operation

Monday- Thursday: 8:00 am - 4:30 pm. (We are closed for lunch from 12:00-12:45)

Friday: 8:00 am - 12:00 pm

Please Note: We will be turning the phones over to the answering service 1 hour

prior to closing in order to return patient calls.

## **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 without patient approval. Therefore, please sign the phone message consent form in order for the staff to leave messages for normal results.

## **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, Medicare Advantage products (such as Blue Advantage) and most other insurance companies. It is the patient's responsibility to reach out to their insurance company to determine if they will pay in-network benefits.

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.

## **Prescription Refill Policy:**

We prefer to refill your medications at the time of your office visit and will provide enough to last until your next office visit. Please bring your medicine bottles and/or a detailed list 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 (through 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 the nurse line. Please leave a message with 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 providers have 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:**

Please leave a message on the nurse line and a nurse will call you back. Please do not leave multiple messages as this slows down the process. Message left after 3:30 pm will be returned the following day.

Our phones are answered by our staff from 8:00 to 3:30 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 line. For more detailed questions, you may be asked to schedule an appointment.

It is difficult to say how soon we will get back to you as it depends on the number of patients we are seeing

**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 3:30 P.M or Friday 8:00 A.M. to 11:00 A.M. Your cardiologist or nurse practitioner will review your problem and medical record then a nurse will call you back with your physician's instructions. After hours, you can leave an urgent message with the answering services and they will notify the cardiologist on call. Non urgent messages will not be taken and you will be instructed to call the office the following day.

**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 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

## **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 \$25 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 early you will be asked to wait to check-in and 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.