CARDIOVASCULAR AND THORACIC SURGERY PARTNERS AT VIRGINIA HOSPITAL CENTER

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2012

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP). If you have any questions about this notice, please contact Gale Yoder at 703-558-6491.

WHO WILL FOLLOW THIS NOTICE:

- Cardiovascular and Thoracic Surgery Partners at Virginia Hospital Center, PLLC.

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosures of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Appointment Reminders**
- **Research**
- **To Provide Information About Organ and Tissue Donation**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition; each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Gale Yoder. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgment of Receipt of Notice of Privacy Practices

I, ______________________________________, have received the Notice of Privacy Practices from Cardiovascular & Thoracic Surgery Partners at Virginia Hospital Center, PLLC.

X_______________________________________ Date:___________________

In lieu of patient signature, I, ____ a staff member of Cardiovascular & Thoracic Surgery Partners at Virginia Hospital Center, PLLC, state that

___________________________ has been given our current Notice of Privacy Practices.

X______________________________________ Date: _______________________

Cardiovascular And Thoracic Surgery Partners at VHC

E Prescribing Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act of 2003 listed standards that have to be included in an ePrescribe Program.

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Cardiovascular and Thoracic Surgery Partners at VHC can request and use your prescription medication history form other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Cardiovascular and Thoracic Surgery Partners at VHC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name: ______________________________ Date of Birth: _______________

Signature: ________________________________ Date: _________________

Relationship to Patient: ___________________

Consent Denied/Revoked:

Signature: ________________________________ Date: __________________

PATIENT'S AUTHORIZATION

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Individual Patient's Name: ______________________________

Your Address: ______________________________

Your Address: ______________________________

Your Telephone Number: ______________________________

Your Social Security Number: ______________________________

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and/or use your protected health information.

____

____

____

3. ENDING THIS AUTHORIZATION

Select one of the following two choices:

- This authorization will end on the following date: ______________________________
- This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

____

____

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the privacy officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

5. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization.

______________________________ ______________

SIGNATURE DATE

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name ______________________________
PRINTED NAME

____
SIGNATURE

Relationship to Individual Patient ______________________________

CARDIOVASCULAR AND THORACIC SURGERY PARTNERS
AT VIRGINIA HOSPITAL CENTER

PATIENT REGISTRATION

Please sign, detach and return with copy of ID cards ACCT # ____________________

PATIENT NAME	SOCIAL SECURITY NO.	TELEPHONE ( )

HOME ADDRESS	CITY	STATE	ZIP CODE	E-MAIL ADDRESS

DATE OF BIRTH	AGE	SEX ❑ M ❑ F	MARITAL STATUS ❑ S ❑ M ❑ D ❑ SEP ❑ W	STUDENT ❑ FULL TIME ❑ PART TIME	NAME OF SCHOOL

EMPLOYER (Patient) FORMER EMP. IF RETIRED / DATE	JOB TITLE	CELL PHONE ( )	WORK TELEPHONE & EXT. ( )

EMPLOYER'S ADDRESS (If military, branch of service)	CITY	STATE	ZIP CODE

NAME OF SPOUSE OR PARENT HOME ADDRESS / EMERGENCY CONTACT	CITY	STATE	ZIP CODE	TELEPHONE ( )
EMPLOYER (Spouse/Parent) EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE ( )

CARDIOLOGIST / REFERRED BY	PRIMARY CARE PHYSICIAN

Have you or any member of your family been a patient here before? If so, who? ____________________

PRIMARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY # (Medicare Patients List A or B)	GROUP / CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY NUMBER	PHONE # FROM ID CARD
	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY # (Medicare Patients List A or B)	GROUP / CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY NUMBER	PHONE # FROM ID CARD
	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT
TERTIARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY # (Medicare Patients List A or B)	GROUP / CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY NUMBER	PHONE # FROM ID CARD
	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT

PATIENT AUTHORIZATION

I hereby authorize Cardiovascular and Thoracic Surgery Partners at Virginia Hospital Center, PLLC ("CVTSP") to apply for my medical insurance benefits, including any major medical benefits on my behalf, for covered services rendered by CVTSP and hereby assign and authorize payment of such benefits directly to CVTSP (or in the case of Medicare, Part B benefits, to myself or to the CVTSP provider who rendered services to me). I certify that the information I have reported to CVTSP with regard to my insurance coverage is true and correct and agree to notify CVTSP of any changes to such information prior to receiving services from CVTSP. I authorize CVTSP to release any necessary information, including but not limited to my medical information, for purposes of furthering my medical care and for processing and receiving payment for services rendered to me, to other providers participating in my care, to my insurance carrier or its designees, or in the case of Medicare Part B benefits, to the Social Security Administration and/or the Health Care Financing Administration or their respective designees. A copy of this Authorization may be used in place of the original.

The Authorization and payment is made in Arlington, Virginia on this ________day of ____________________, 20______

X ______________________________
PATIENT

X ______________________________
INSURED OR RESP. PARTY OTHER THAN PATIENT

X ______________________________
GUARANTOR

PLEASE SIGN ABOVE WHERE APPLICABLE

CARDIOVASCULAR & THORACIC SURGERY PARTNERS AT VIRGINIA HOSPITAL CENTER, PLLC
HISTORY & PHYSICAL

Name________________________ **Age**________ **Birthdate**________________ **Today's Date**____________

ALLERGIES________________________ **SS #**____________________ **Phone#**________________

What is the main reason you are here? ____

List your symptoms:

____

____

____

List all of your current physicians:

____

____

____

Medical History	Past Surgical History	Current Medications

Review of Systems: Do you have / have you had any of the below symptoms? Please circle all that apply.

Recent change in weight	Loss of Appetite	Recent/Frequent Fevers	Fatigue	Night Sweats	
Frequent headaches	Sore Throat	Swollen glands	Dentures	Dental problems	Difficulty swallowing
Chest Pain/Angina	Varicose veins	Pain in calf when walking or at rest	Swelling in arms/legs/ankles		
Frequent cough	Productive cough	Cough up blood	Shortness of breath	Require more than one pillow to sleep	
Frequent vomiting Ulcers	Vomit blood Gallstones	Liver problems Frequent diarrhea	Constipation Bright red blood from rectum	Hemorrhoids	Black tarry stools
Kidney Disease	Frequent urination	Pain with urination	Hesitancy with urination	Prostate problems	
Stroke/Mini-stroke	Weakness	Numbness/tingling sensation	Seizure		
Arthritis	Aching in arms/hands or legs/ankles	Hernia	Artificial Joints		
Diabetes	Thyroid problems	Excessive thirst			
Bleeding tendencies	Easy bruising	Skin infections	Open skin wounds		

Marital Status:	Occupation:
Live Alone?	Alcohol (how many drinks per day/month?):

History of Smoking? Yes No
How old when you started? Packs per day? When did you stop?

How tall are you? What is your weight? What was your weight one year ago?

Age and state of health / or cause of death of your:
Father: Mother
Brother/Sister: Children:

PATIENT IDENTIFICATION

Do you have: A living will?
A durable power of attorney for healthcare?

Are you an organ donor? Yes / No