The Heart & Vascular Center OF SARASOTA

WWW.HEARTCENTER.COM

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE READ AND COMPLETE THE ENTIRE FORM.

Patient Name:_____ **Patient Address:**_____
Date Of Birth:_____ **Preferred Phone #:** _____
Home Phone #: _____ **Cell Phone #:**_____
Email:_____ **Preferred Pharmacy:**_____

Primary Care Physician: _____

I authorize the Heart & Vascular Center of Sarasota to use and disclose a copy of the specific health and medical information described below:

** ( ) Send records to:

_____
Name of Physician or Facility

_____
Complete Street Address

_____
City State Zip Code

_____
Telephone/Fax No.

** ( ) Obtain records from:

_____
Name of Physician or Facility

_____
Complete Street Address

_____
City State Zip Code

_____
Telephone/Fax No.

Office Use Only: ( ) Continued Medical Care ( ) Patient Use **Patient Appt. on:**_____
Information to be released:_____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services/treatment to you on receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and,
- We must provide you with a copy of the signed authorization.

1217 S. East Ave, Suite 104, Sarasota, FL 34239 ♥ (P) 941-365-0433 ♥ (F) 941-954-2064

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request. A photocopy of this authorization shall have the same effect as the original.

I understand that my record may contain information about alcohol and/or drug treatment, mental health or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above.

I understand the Heart & Vascular Center of Sarasota may utilize a medical records correspondence service and that there may be a fee assessed for this service.

PLEASE ALLOW 7 TO 10 BUSINESS DAYS FOR RECORDS TO BE COPIED.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

COST OF REPRODUCING MEDICAL RECORDS

64B8-10.003 Costs of Reproducing Medical Records:

1. Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records
2. Reasonable cost of reproducing copies of written or typed documents or reports shall not be more that the following:
    a) For the first 25 pages, the cost shall be $1.00 per page.
    b) For each page in excess of 25 pages, the cost shall be 25 cents.
3. Reasonable costs of reproducing X-rays, and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

X _____ _____ _____

Signature of Patient/Legal Representative | Relationship to Patient | Date

Credit(s):
Specific Authority 458.309 FS. Law Implemented 455.674, 455.677, 458.331(1) FS. History – New 11/17/87, Amended 5/12/88, Formerly 21M-26.003, 61f6-26.003, 59r-10.003.

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The Heart & Vascular Center OF SARASOTA

PATIENT FINANCIAL POLICY

Dear Patient:

Thank you for choosing the Heart and Vascular Center of Sarasota, Inc. (HVCS) as your healthcare provider. We are committed to providing you the highest quality, most affordable healthcare service available. In order to do so, we have established the following Financial Policy which we request you read agree to and sign before services are provided. A copy will be provided to you upon request.

It is the policy of HVCS to help keep your health care costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

1. Always bring your current health insurance card to the office.
2. Please notify us prior to your appointment of any changes to insurance, address, telephone or family status.
3. Please pay your co-pay, balances or deductible at the time of service.

You will be expected to pay in full if:

1. You do not have insurance (Self-Pay).
2. HVCS does not participate with your health plan.
3. You are unable to present a valid member identification card from your insurance carrier at your visit.
4. We are unable to verify your insurance coverage.
5. You have a pre-existing condition or other diagnosis that may not be covered by your plan.
6. You have not met the deductible under your health plan contract.
7. Routine services may not be covered by some insurance plans.

You should receive a bill for any charges that are your responsibility within 30 days of service; and/or an explanation of benefits (EOB) from your insurance company. Please provide your name, physician in reference, phone number to the service and someone from the billing office will return your call within 48 hrs.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.

Payment Options if you have insurance: We are required by our insurance contracts to collect all copays and other patient responsible amounts, at the time of service. To assist you, we accept cash, checks or credit/debit card.

It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, we suggest that you verify coverage limitations prior to being treated.

Patient Name: **X**_____ Date:_____ DOB:_____

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Patient Financial Policy Continued:

If your insurance company has not processed your account within 90 days from the date of service, the balance will automatically be sent to you. Your signature on this form indicates that you authorize HVCS to bill your insurance company directly for services rendered and for your insurance company to make payment directly to HVCS.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs including a collections fee that may be added to the account

If we need to send the account balance to collection because of non-payment of the account, our physicians may no longer be able to provide care. In this case, the person responsible for the account will be notified of this by certified mail and given adequate time to find a new medical provider.

All accounts sent to the collection agency will be reported to the Credit Bureaus.

Returned Checks: There is a fee (currently $36.00) for any checks returned by the bank. This amount may change.

Fee for missed appointments and appointments canceled without 24 hour notice: A Fee of $50.00 will be charged to your account for each appointment that was missed or not cancelled at least 24 hours prior to the appointment.

Copies and Transfer of Records: All past due amounts will be collected before medical records are copied or transferred. A nominal fee is assessed to cover co-pay costs.

Effective Dates: Once you have signed this agreement, you agree to all of the terms and conditions contained herein for this and any future visits, and the agreement will be in full force and effect.

Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency for collections, the undersigned shall pay all collection agency fees and risk being dismissed from the physician care of HVCS.

I have read this Patient Financial Policy, as outlined, and understand that I am ultimately responsible for the charges incurred by me or by the child/children as their legal parent or guardian.

This is an agreement between HVCS as creditor, the Patient, Guardian/Guarantor, or Parent as debtor, named on this form

In this agreement, the words "you", "your" and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to the Heart and Vascular Center of Sarasota, Inc.

By executing this agreement, you are agreeing to pay for all services that are received.

X _____ _____

Signature of Patient or Legal Guardian | Date

X _____ _____

Patient Name | Name of Legal Guardian

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The Heart & Vascular Center OF SARASOTA

The Heart and Vascular Center Appointment Scheduling and Cancellation Policy

At the Heart and Vascular Center of Sarasota, Inc. we strive to provide excellent care to all of our patients and to schedule appointments so as to accommodate the needs and preferences of our patients.

We typically schedule routine appointments for Office Visits or Testing that the Doctor or ARNPs have ordered at checkout or we will put you in our reminder system and call you several weeks before the appointment is due to schedule.

We ask that you always promptly enter your appointments on your calendar.

We sometimes have to change your appointments due to a provider or technician being unavailable or due to a technical problem. In those cases we will always give you as much notice as possible.

If you have to cancel or reschedule an appointment with us, we ask that you **contact us as soon as you can, or a minimum of 24 hours in advance**, so we may try to fill your spot with someone from the wait list. Dr. Bredlau and the Nurse Practitioners are booked out for months in advance, and we need to be able to use cancellation spots to fill urgent needs. Missed appointments place a significant financial burden on our office.

Not notifying us at least 24 hours in advance or missing an appointment will now result in a fee of:

- **$50.00 per appointment**
- **$100.00 for a missed Stress Test appointment.**

If you have multiple appointments scheduled on the same day, you could be charged multiple no-show fees. Payment on these fees is due before the appointment/s can be rescheduled.

Please be sure to give us more than one phone number and / or email address to reach you at, and please notify us immediately of any changes. We typically call confirms on appointments, but not receiving a reminder call does not relieve you of your responsibility to keep track of and show for your appointments.

Thank you for your cooperation!

Acknowledged by:

X _____ _____

Patient Signature Date

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The Heart & Vascular Center OF SARASOTA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

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

I have the right to review the Notice of Privacy Practices prior to signing this consent. Heart & Vascular Center of Sarasota reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Heart & Vascular Center of Sarasota, Privacy Officer at 1851 Hawthorne Street, Sarasota, FL 34239.

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

With my consent, Heart & Vascular Center of Sarasota may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Heart & Vascular Center of Sarasota may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Heart & Vascular Center of Sarasota restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Heart & Vascular Center of Sarasota's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Heart & Vascular Center of Sarasota may decline to provide treatment to me.

X _____ _____

Signature of Patient or Legal Guardian | Date

X _____ _____

Patient Name | Name of Legal Guardian

The Heart & Vascular Center OF SARASOTA

Assignment of Insurance Benefits
Medicare and Supplemental Insurance

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to Heart & Vascular Center of Sarasota on my behalf.

I authorize Heart & Vascular Center of Sarasota to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, Heart & Vascular Center of Sarasota may prescribe testing procedures to be performed here. I understand the Heart & Vascular Center of Sarasota is the owner, and I have been advised that according to Florida Law I am under no obligation to use this facility.

I understand that I am responsible for payment of any non-covered service, deductible, and/or co-payment due.

X_____ _____

Signature Date

COMMERCIAL INSURANCE

I request that payment of authorized benefits be made on my behalf to Heart & Vascular Center of Sarasota for any services provided by Heart & Vascular Center of Sarasota physicians. I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. *I understand that I am responsible for payment of any charges in full, including non-covered services, deductible and/or co-payments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. Heart & Vascular Center of Sarasota will request a pre-authorization from your insurance company on procedures ordered by Heart & Vascular Center of Sarasota. It is your responsibility to ensure that an authorization is on file with Heart & Vascular Center of Sarasota prior to having your procedure performed. When applicable, I understand that I am responsible for payment of all charges in full due to no authorization.*

X_____ _____

Signature Date

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The Heart & Vascular Center
OF SARASOTA

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have read the **HEART & VASCULAR CENTER OF SARASOTA Notice of Privacy Practices** with the effective date of January 1, 2020.

X _____

Patient Name (please print)

X _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Copy requested and given to Patient: Yes ☐ No ☐

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The Heart & Vascular Center OF SARASOTA

Permission to Release Information to Non-Medical Persons

Emergency Contacts & Advanced Directive Information

Please list any family members (including spouse), friends or home health care personnel you authorize to receive information on your medical condition (e.g. test results, hospital status appointment information etc.) or billing information.

I,_____wish the following person to be contacted in an emergency:

1) Name_____Relationship_____Phone_____

I,_____give the Heart &Vascular Center of Sarasota permission to release medical/billing information to the following people:

1) Name_____Relationship_____Phone_____

2) Name_____Relationship_____Phone_____

Do you have an Advanced Directive / Living Will: YES:____ NO:____
Do you have a DNR (Do Not Resuscitate) in place? YES:____ NO:____
If YES to either the above, please provide HVCS a copy

1) Power of Attorney:_____Phone_____

2) Health Care Surrogate:_____Phone_____

X_____ _____

Patient Signature **Date**

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Permission for E-Mail Communication

Please be advised that email is not considered a secure or HIPPA compliant way of communicating.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

If you are willing to accept that risk and would like to be able to communicate with the office via email, please fill out and sign the information below.

I hereby authorize **The Heart & Vascular Center of Sarasota** to send e-mail correspondence to me containing the following information:

1. Appointment information yes ( ) no ( )
2. Billing information yes ( ) no ( )
3. Medical information (Test Results etc.) yes ( ) no ( )

Patient Name:_____ Date:_____

E-mail Address:_____

X_____

Signature of Patient or Authorized Representative

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