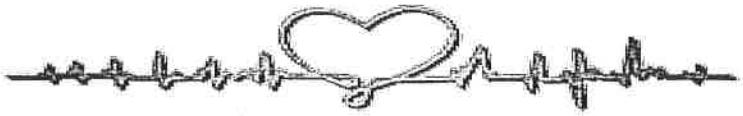

NANTICOKE CARDIOLOGY PA

SEAFORD, DE

We are often asked by patients to leave messages or provide information regarding protected health information with immediate family or with close friends. Sometimes this is for convenience (such as having someone pick up information from our office) and sometimes this is necessary (such as in the case of a serious illness during which you may be too ill to keep your family informed of your health condition). Please specify the name of any person(s) to whom we may release all information pertinent to your health and/or payment for your healthcare by Nanticoke Cardiology.

_____	_____
Name/Relationship	Phone Number
_____	_____
Name/Relationship	Phone Number
_____	_____
Name/Relationship	Phone Number

The above person(s) may receive all health information about my appointments, treatment, or other information pertinent to my healthcare or payment for healthcare. This authorization is effective through _____. I understand that I may revoke this authorization at any time in writing.

_____	_____
Patient Signature	Date

NANTICOKE CARDIOLOGY PA
SEAFORD, DE

Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with quality and affordable health care. Some patients have had questions regarding patient and insurance responsibility, so we are providing this financial policy. Please read and sign in the space provided. A copy will be provided to you upon request.

- **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at the time of service. If you are insured by a plan we do business with but do not present a valid insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- **Co-payments and Deductibles:** All co-payments and deductibles are the patient's responsibility. **Co-payments must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect your co-payment can be considered fraud. Please help us to uphold the law by paying your co-payment at each visit.
- **Claim Submission:** We will submit your claim and work diligently to get your claim paid. However, there are times that your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with such requests.
- **Patient Balances:** We send statements monthly for all balances that have been transferred to patient responsibility. Payment in full is expected, unless a payment plan has been approved by our billing department. If balances are not paid timely, your account may be referred to a collection agency.
- **Missed Appointments:** We will charge a **$35.00** fee for missed appointments. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your scheduled appointment. If you find you cannot keep an appointment, please call us as soon as possible to cancel or reschedule but at least within **24 hours** of your scheduled appointment.

I have read and understand the financial policy.

_____ _____

Signature of patient or responsible party Date

NANTICOKE CARDIOLOGY PA
SEAFORD, DE

Patient Insurance Information

Insurance Information: Primary Insurance: _____

Identification Number: _____

Secondary Insurance: _____

Identification Number: _____

Information needed if insurance coverage is under a spouse/ parent/ or a legal guardian:

Name of responsible party: _____

Date of Birth: _____

Social Security #: _____-_____-_____ (required for billing purposes)

No Insurance: _____ Other: _____

Responsible Party for patient seen above: _____

Patient Intake Form

NANTICOKE CARDIOLOGY PA
SEAFORD, DE

Patient Name _____ DOB _____ Age _____ Date _____

Primary Care Physician _____ Referring Physician _____

PLEASE ANSWER ALL QUESTIONS

What is your reason for today's visit? _____

1. When did the problem/discomfort start? _____
2. Where is the problem/discomfort located? _____
3. What makes it worse? _____
4. If there are any other symptoms associated with this problem please describe _____

_____

GENERAL REVIEW OF SYSTEMS Are you currently having any of the following symptoms? (Please circle yes or no)

Constitutional:
Y N Recent weight change
Y N Fever
Y N Chills
Y N Fatigue

Eyes:
Y N Blurred/impaired vision

ENT:
Y N Hearing loss
Y N Ringing in ears
Y N Nose bleeds
Y N Bleeding gums
Y N Sore throat or voice change
Y N Swollen glands in neck

Cardiovascular:
Y N Chest pains/discomfort
Y N Sudden heart beat changes
Y N Palpitations/racing heart beat
Y N Swelling of feet, ankles or hands

Respiratory:
Y N Frequent coughing
Y N Sputum productive cough
Y N Spitting up blood
Y N Shortness of breath
Y N Asthma or wheezing

Gastrointestinal:
Y N Loss of appetite
Y N Change in bowel movements
Y N Nausea
Y N Vomiting
Y N Frequent diarrhea
Y N Painful bowel movements/constipation
Y N Blood in stool
Y N Stomach pain
Y N Heartburn
Y N Reflux

Genitourinary:
Y N Frequent urination
Y N Burning or painful urination
Y N Blood in urine
Y N Incontinence or dribbling
Y N Kidney stones
Y N Sexual difficulty
Y N Erection Problems

Musculoskeletal:
Y N Joint pain
Y N Joint stiffness or swelling
Y N Weakness of muscles/joints
Y N Muscle pain or cramps
Y N Back pain
Y N Cold extremities
Y N Leg pain with walking
Y N Leg swelling
Y N Limb weakness

Skin:
Y N Rash
Y N Itching skin
Y N Change in skin color
Y N Varicose veins
Y N Easily bruise
Y N Non-healing sores

Psychiatric:
Y N Memory loss or confusion
Y N Nervousness
Y N Depression
Y N Sleep problems
Y N Suicidal thoughts

Neurological:
Y N Syncope/Passing out
Y N Near Syncope
Y N Headaches
Y N Lightheaded
Y N Dizziness
Y N Convulsions or seizures
Y N Numbness or tingling
Y N Tremors
Y N Paralysis
Y N Stroke
Y N Head injury
Y N Slurred speech

Endocrine:
Y N Thyroid disease
Y N Diabetes
Y N Excessive thirst
Y N Excessive urination
Y N Heat or cold intolerance
Y N Dry skin

Hematologic/Lymphatic:
Y N Slow to heal after cuts
Y N Bleeding tendencies
Y N Anemia

Adverse Reactions to:
Y N Penicillin or antibiotics
Y N Morphine. Demerol, narcotics
Y N Novocain, other anesthetics
Y N Aspirin or other pain remedies
Y N Tetanus antitoxin, other serum
Y N Iodine, methiolate, antiseptics

List all allergies that you have: _____

_____

_____

_____

Patient Signature _____ **Date** _____

Please See Reverse Side

NANTICOKE CARDIOLOGY PA
SEAFORD, DE

Please list all PRESCRIPTION medications that you take

Name	Dose	Frequency

List all OVER THE COUNTER medications that you take

Name	Dose	Frequency

Past Medical History: (Check all that apply)

_____ Heart Disease
_____ Heart Valve Problems
_____ Pacemaker
_____ Heart Failure
_____ Heart Block
_____ Hereditary Heart Defect
_____ Heart Murmur
_____ Atrial Fibrillation

_____ Previous Heart Attach
_____ High Blood Pressure
_____ High Cholesterol
_____ Blood Clot in Legs
_____ Blood Clot in Lungs
_____ Lung Problems
_____ Emphysema
_____ Anuerysm

_____ Asthma
_____ COPD
_____ Thyroid Disease
_____ Liver Disease
_____ Kidney Disease
_____ Stroke
_____ Diabetes
_____ Sleep Disorder

_____ Cancer
_____ Bleeding Disorder
_____ HIV Disease/exposure
_____ Hepatitis (A, B or C)
_____ Anticoagulation
_____ Atrial Flutter
_____ Anemia
_____ Other

Please provide information about previous surgeries and hospitalizations (include date or year)

Surgeries / Procedures		Hospitalizations	
Coronary Bypass	Date	Admitted for	Date
Cardiac Cath	Date		Date
Angioplasty / Stent	Date		Date
Pacemaker	Date		Date
Defibrillator	Date		Date
Other	Date		Date
	Date		Date

Please provide information about previous testing (include date and location)

Stress Test	Date _____	Location _____	Holter Monitor	Date _____	Location _____
Nuclear Test	Date _____	Location _____	Event Monitor	Date _____	Location _____
Echo	Date _____	Location _____	Heart Scan	Date _____	Location _____
24 hr BP Monitor	Date _____	Location _____	PAD Net	Date _____	Location _____

Does anyone in your family have or had Heart Disease, Heart Attack, Stroke, High Cholesterol, High Blood Pressure, Diabetes, Diabetes, Sudden Death or Cancer?

Father	Age _____	Disease(s) _____	Cause of death, if deceased _____
Mother	Age _____	Disease(s) _____	Cause of death, if deceased _____
Siblings	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____

Social History:

Cigarette Smoking:	Never	Current: _____ pack(s) per day, _____ year's total			Previous: _____ year quit
Use of Alcohol:	Never	Rare/Social	Moderate	Daily: amount per day _____	Previous: _____ year quit
Use of Caffeine:	Never	Rare/Social	Moderate	Daily: amount per day _____	Previous: _____ year quit
Exercise Level:	Never	Rare	Moderate	Daily, _____ times per week.	Type of exercise: _____
Special Diet:	Low Fat	Low Cholesterol	Vegetarian	Other _____	
Occupation: _____	Full time	Part time	Retired	Unemployed Other _____	
Recreational Drugs:	Never	Rare/Social	Moderate	Daily: amount per day _____	Previous: _____ year quit

Patient Signature _____ **Date** _____

NANTICOKE CARDIOLOGY PA
SEAFORD, DE

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand the Nanticoke Cardiology P.A. Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that Nanticoke Cardiology P.A. may update its Notice of Privacy Practices at any time and that I may receive and updated copy by submitting a request in writing.

_____

Printed Patient Name

_____ _____

Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____

Printed Patient Personal Representative Name Relationship to Patient

_____ _____

Patient Personal Representative Signature Date

For Nanticoke Cardiology, P.A. Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Nanticoke Cardiology, P.A. made a good faith effort to obtain patient's written acknowledgement of the Notice of Privacy Practices but was unable to do so for the reason documented below.

- o Patient or patient's personal representative refused to sign.
- o Patient or patient's personal representative unable to sign.
- o Other

_____

Employee Name (printed)

_____ _____

Employee Signature Date

NANTICOKE CARDIOLOGY, P.A. NOTICE OF PRIVACY PRACTICES

1. Introduction

Nanticoke Cardiology, P.A. is required by law to maintain the privacy and security of your health information and provide individuals with notice of its legal duties and privacy practices with respect to health information. Nanticoke Cardiology, P.A. is required to abide by the terms of the Notice currently in effect. Nanticoke Cardiology, P.A. reserves the right to change the terms of this Notice at any time and to make new Notice provisions effective for all health information that it maintains. Upon your request, we will provide you with a current copy of this Notice.

This Notice of Privacy Practices outlines our practices and legal duties to maintain the confidentiality of your protected health information ("PHI") under the privacy and security regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI includes demographic information that can be used to identify you such as your name, address and telephone number; information concerning your past, present, or future physical or mental health condition; information concerning the provision of health care to you and information concerning the past, present or future payment for health care. Your PHI may be maintained by us electronically and/or on paper.

This notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with Nanticoke Cardiology, P.A.

If you have any questions about the Nanticoke Cardiology, P.A. Notice of Privacy Practices, please contact the Privacy Officer, Brenda Rubino at 302-629-9099 or in writing at 200 Federal Street, Seaford, DE 19973.

2. Safeguarding Your PHI

We have in place appropriate administrative, technical and physical safeguards to protect and secure the privacy and security of your PHI. We train our employees on the regulations and policies that are in place to protect the privacy and security of your PHI. Medical records are maintained in secure areas within our practice and electronic medical record systems are monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only employees who have a legitimate "need to know" are permitted access to your medical records and PHI. Our employees understand their legal and ethical obligations to protect your PHI and that a violation of this Notice of Privacy Practices may result in disciplinary action.

3. Uses and Disclosures of PHI

As part of our registration materials, we will request your written consent for our practice to use and disclose your PHI for the following types of activities: Treatment, Payment, Health Operations.

When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. Electronic Exchange of PHI

We may transfer your PHI to other treating health care providers electronically, We may also transmit your information to your insurance carrier electronically.

5. Uses and Disclosures of PHI Requiring Your Written Authorization

Uses and disclosures of your PHI made for purposes of psychotherapy, marketing and disclosures that constitute a sale of your PHI will be made only with your written authorization.

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that Nanticoke Cardiology, P.A. disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment or health care operations, such as family members or a school physical education program. If you wish us to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

If Nanticoke Cardiology intends to engage in fundraising, you have the right to opt out of receiving such communications. If you authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose your PHI for the reasons contained within your authorization. However, we cannot take back disclosures already made with your permission.

6. Uses and Disclosures of PHI Permitted or Required by Law

In some circumstances, we may be legally permitted or required to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to: Emergencies, Others Involved In Your Healthcare, Communication Barriers, Required by Law, Public Health/Regulatory Activities, Food & Drug Administration, Health Oversight Activities, Judicial & Administrative Proceedings, Law Enforcement Activities, Coroners & Medical Examiners, Funeral Directors & Organ Donation Organizations, Research, Serious Threats to Health or Safety, Military& National Security Activities, Worker's Compensation, Inmates of a Correctional Facility, U.S. Department of Health & Human Services and Disaster Relief Activities.

7. Your Rights Regarding PHI

- Right to Request Restrictions for Certain Uses and Disclosures: You have the right to request that we not use or disclose your PHI unless such a use or disclosure is required by law. Such a request must be made in writing and include the specific PHI you wish restricted as well as the individual(s) who should not receive the restricted PHI. If we agree to your request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. However, we are not required to agree to your requested restriction except in the case of restricting disclosure of PHI to a health plan as follows. If you request a restriction on certain uses and disclosures of your PHI to a health plan for a particular health care item or service where said health care item or service is paid for out of pocket and in full, we will abide by your request. Such a request must be made in writing to the practice Privacy Officer. Your request must describe in a clear and concise fashion the health care item or service you wish restricted.
- Right to Access: You have the right to inspect and obtain a copy of your PHI. You may request copies of your PHI in either paper or electronic form. In very limited circumstances, we may deny access to your PHI. To request access to your PHI, please submit a request in writing to the practice Privacy Officer including whether you want your copy in electronic or paper form. We will respond to your request as

soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial letter within 30 days. If access is denied, an appeals process may be available in certain cases. We have the right to charge a reasonable fee for providing copies of your PHI (and for electronic media, if applicable). Furthermore, you may request that a copy of your PHI be transmitted directly to a third party provided such request is made in writing, signed by you and clearly identifies the designated third-party and location to send your PHI.

- Right to Confidential Communications: You have the right to request to receive communication of PHI by alternative means or at alternative locations. For example, may wish your bill to be sent to an address other than your home. Such requests must be in writing to the practice Privacy Officer. We will not require an explanation of your reasons for the request and will accommodate reasonable requests.
- Right to Amend: You have the right to request your PHI. Your request must be made in writing. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial. Nanticoke Cardiology has the right to submit a rebuttal statement. A record of any disagreement regarding amendments will become part of your medical record and may be included in subsequent disclosures of your PHI.
- Right to an Accounting of Disclosures: Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those made for purposes of treatment, payment or health care operations. Please make your request in writing to the practice Privacy Officer. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with one accounting every 12 months free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.
- Right to a Copy of our Notice of Privacy Practices: We will ask you to sign a written acknowledgement of receipt for our Notice of Privacy Practices. We may update this Notice of Privacy Practices at any time. Upon your request, we will provide you with a current copy of this Notice.
- Right to Notice of Breach: You have a right to receive notice if there has been a breach of your unsecured PHI.

8. Complaint Procedure

- Within Our Practice: If you have a complaint about the denial of any of the specific rights listed above, about our Notice of Privacy Practices, or about our compliance with state and federal privacy laws you may receive more information about the complaint process by contacting the practice Privacy Officer at 302-629-9099.
- Outside Our Practice: If you believe that Nanticoke Cardiology, P.A. is not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health & Human Services, Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

9. Effective Date: This Notice is effective as of September 23, 2013.