NANTICOKE CARDIOLOGY PA

SEAFORD, DE

Patient Name: _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

-Healthcare information regarding from prior practice(s) may be made available to coordinate patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

-If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

-Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Member

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY

DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name:_____ Date:_____

_____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date:_____

Patient Name (Printed): _____ DOB:_____

Patient Financial Responsibility Guidelines

Nanticoke Cardiology is pleased you have chosen our practice for your medical care. Quality care is a first priority among our providers. To reduce confusion and keep costs of your care to a minimum, Nanticoke Cardiology requests that you please read the following guidelines to understand your financial responsibility and requirements.

Patients with Health Insurance

- Please provide a copy your insurance card to each visit so that the office staff can verify your eligibility.
- Not all services may be covered by your insurance plan therefore the obligation to understand what services are covered remains with you. Please contact your insurance carrier regarding covered services.
- If verification of your insurance plan not be determined at the time of your visit, payment in full is required; upon verification, you will be refunded.
- If your insurance requires a referral to see one of our providers for specialty care, please contact your PCP's office. The referral will need to be in place prior to your visit.

Co-Payments and Deductibles

- Co-payments will be expected on each date of service when required by your insurance. Failure on our part of collect would be considered fraud under the guidelines of the health plan.
- Co-payments and deductible are the patient's responsibility per your insurance plan.
- If you have questions regarding your co-pay amount, please call your health plan directly.

Patient Balances

- Our practice is required to balance bill patients after payment by the insurance company.
- Patients will receive a monthly statement.
- Payment is expected in full unless a payment plan has been set up by our billing manager.
- Please understand if payments are not made in full or paid on the monthly plan, your account will go to our collection agency.

Self-Pay Patients

- Payment in full is required for services provided in the physician office. It is expected at the time of your visit.

No Shows

- We require 24 hours cancellation notice if you are unable to keep your appointment.
- Please understand that you may be charged a $35.00 No Show fee for missed appointments.

Billing Questions

We realize that special circumstances may arise and will assist you in every way we can to resolve your outstanding balances. To apply please contact our Billing department.

Please understand we reserve the right to transfer delinquent accounts to a collection agency after all efforts have been exhausted to obtain payment from you.

Statements sent to you from the practice after receipt by payor. Hospital, laboratory and radiology services may be billed to you separately from those facilities. Please call them directly when bill questions arise.

Please feel free to contact our Billing department with any questions at **(302) 629-9099 option 6** between the hours of **9:00am-4:00pm, Monday – Friday.**

X ***Patient Signature***_____***Date:*** _____

I acknowledge receipt of these patient financial responsibility guidelines.

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: _____

_____

_____

_____

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

Authorization for Release of Information

PATIENT NAME: _____ DATE OF BIRTH: _____-_____-_____

ADDRESS: _____ SS#: _____-_____-_____

HOME PHONE: CELL PHONE

I hereby authorize _____to release information from my medical record as indicated below to:

NANTICOKE CARDIOLOGY, P.A.
200 FEDERAL STREET
SEAFORD, DELAWARE 19973

PHONE: **302-629-9099** FAX: **302-536-0053**

INFORMATION TO BE RELEASED:

	DATES:
❑ History and physical exam	_____
❑ Progress notes	_____
❑ Lab reports	_____
❑ X-ray reports	_____
❑ Other: _____	_____
_____	_____

I specifically authorize the release of information relating to:
- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)

X_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care
❑ Legal ❑ School ❑ Insurance ❑ Workers Compensation
❑ Other (please specify): _____

I understand that this authorization will expire on _____days after I have signed the form. I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand that if I am being requested to release this information by _____ (Print Name of Provider) for the purpose of:
_____
_____

a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
c. I have been informed that _____ (Print Name of Provider) ❑ will/ ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

I understand that in compliance with Delaware statute, I will pay a fee of $_____ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

Nanticoke Cardiology, P.A.
Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA) Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments.

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

PLEASE REVIEW THIS NOTICE CAREFULLY

If you have any questions about this notice or if you need more information, please contact:

Nanticoke Cardiology, P.A.
Attn: Diane Capoferri, Privacy Officer
200 Federal Street
Seaford, DE 19973

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of Be Well Medical Center. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect. You may download the form by clicking here.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- Treatment. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- Payment. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

- Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

- Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

In some circumstances, we may be legally or required to use of disclose your PHI without your consent or authorization. State and federal privacy laws permit or require such use or disclosure regardless of your consent or authorization in certain situations, including but not limited to: Research, Serious threat to health or safety, Organ and Tissue donation organizations, Emergencies, Others involved in Your Healthcare, Communication Barriers, Required by Law for international, federal, state, or local law, Military & National Security Activities, Judicial and Administrative Proceedings, Law Enforcement Activities, Food & Drug Administration, Public Health/Regulatory Activities, Funeral Directors, Worker's Compensation, Inmates of a Correctional Facility, U.S. Department of Health and Human Services and Disaster Relief Activities, Health Oversight Activities and Abuse, Neglect or Domestic Violence.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- Inspect and Copy. You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- Summary or Explanation. We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

- Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.

- Receive Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

- Request Amendments. If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request

restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.

- Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

- Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: www.nanticokecardiology.com or contact office.

Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Be Well Medical Center, P.C., Privacy Officer, at the address listed at the beginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Humans Services, 200 Independence Ave., S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. You will not be penalized for filing a complaint.

Please submit all requests in writing to our Medical Records Department, at Nanticoke Cardiology, P.A., 200 Federal Street, Seaford, DE 19973. There may be a charge for transferring medical records.

If you have any questions regarding this notice or the HIPAA privacy policies please contact Diane Capoferri, privacy officer at 302-629-9099 or in writing at 200 Federal Street, Seaford, DE 19973.

Notice Effective 9/23/2013