Peachtree Vascular Specialists, P.C.

Patient Demographic and Insurance Info

Name: **Today's Date:**
Birthdate: **Age** : **SSN:** **Sex:**
Home Address:
City: **State:** **Zipcode:**
Phone Number: **Cellphone #:**

E-mail Address: **May we contact you via e-mail?** **YES** **NO**

Occupation: **May we contact you at work**? **YES** **NO**

Employer: **Years there:**
Employer's Address:
City: **State:** **Zip:**
Work Phone: **Cell Phone:**
Driver's License #:
Spouse's Name: **Birthdate:** **Age**:
Spouse Cell #:
SSN:
Occupation: **Employer:** **Years There:**
Employer's Address:
City: **State:** **Zip:**

Employer's Telephone:

In case of emergency, contact:
Name: **Relationship:**
Home Phone: **Work Phone:** **Cell #:**

How did you learn about our practice?

- ☐ Referring Doctor:
- ☐ My friend, recommended you.
- ☐ Hospital call center
- ☐ My managed care plan book
- ☐ Internet Search

Peachtree Vascular Specialists, P.C.

INSURANCE CARRIER:
Insured's Name: **Group #:** **ID #:**
Relationship to Patient: **Birthdate:** **SSN:**
Cell #: **Telephone #:**
Home Address:
City: **State:** **Zip:**

Name of Secondary Insurance Company:

Are you seeing us due to an INJURY at work? ☐ **Yes** ☐ **No**
IF YES: Date of Injury:
How were you injured?

Employer: **Years There:**
Employer's Address:
City: **State:** **Zip:**

Contact Person:
Contact Phone #:

PLEASE FURNISH YOUR INSURANCE CARDS AND A PICTURE I.D. UPON REQUEST.
THE PATIENT IS RESPONSIBLE FOR ALL PROFESSIONAL SERVICE FEES REGARDLESS OF INSURANCE COVERAGE. Co-Payments must be paid when services are rendered unless arrangements have been made in advance. Appropriate insurance forms will be submitted for all Insurance Carriers.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
I hereby authorize payment directly to **Peachtree Vascular Specialists, P.C.** of any medical benefits otherwise payable to me for services rendered. I understand and agree that I am financially responsible to said physician for any charges not covered by this assignment.

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize the release by PVS of any medical information to any insurance company for the purpose of processing claims for services rendered, and to any physician for the continuance of my medical care:

SIGNATURE: **DATE:**

Peachtree Vascular Specialists, P.C.

HISTORY AND PHYSICAL

Name: _____ Date: _____ Referring M.D.: _____

Other M.D.'s: _____

REASON FOR VISIT:

DRUGS AND MEDICATION:

List all medications you take, including dosage and how often:

1.) _____ 6.) _____

2.) _____ 7.) _____

3.) _____ 8.) _____

4.) _____ 9.) _____

5.) _____ 10.) _____

SURGERIES, HOSPITALIZATIONS AND SERIOUS ILLNESSES:

List all previous operations, hospitalizations and serious illnesses with reason and approximate dates:

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

6.) _____

Do you have any allergies . . . . . ☐ No ■ Yes

If so, to what and type of reaction?

Any anesthesia complication? . . . . . ☐ No ■ Yes

What type? _____

Any bleeding problems? . . . . . ■ No ☐ Yes

What type? _____

Have you ever had a blood transfusion? . . . . . ■ No ☐ Yes

MEDICAL HISTORY AND PROBLEMS

Anemia . . . . . ☐ No ■ Yes

What type? _____

Angina . . . . . ☐ No ☐ Yes

Arthritis . . . . . ☐ No ☐ Yes

Asthma . . . . . ☐ No ☐ Yes

Bladder or kidney infection . . . . . ☐ No ☐ Yes

Cancer . . . . . ☐ No ☐ Yes

What type? _____

Congestive heart failure . . . . . ☐ No ☐ Yes

Diabetes . . . . . ☐ No ☐ Yes

What type? _____

Dialysis . . . . . ☐ No ☐ Yes

When? _____

Where? _____

Diverticulitis . . . . . ☐ No ☐ Yes

Emphysema . . . . . ☐ No ☐ Yes

Gallbladder disease . . . . . ☐ No ☐ Yes

What type? _____

Gastroesophageal reflux disease . . . . . ☐ No ☐ Yes

Heart Attack . . . . . ☐ No ☐ Yes

When? _____

High blood pressure . . . . . ☐ No ☐ Yes

Any other problems? . . . . . ☐ No ☐ Yes

High cholesterol . . . . . ☐ No ☐ Yes

Irregular heart beat . . . . . ☐ No ☐ Yes

What type? _____

Kidney failure . . . . . ☐ No ☐ Yes

Kidney stones . . . . . ☐ No ☐ Yes

Liver disease . . . . . ☐ No ☐ Yes

What type? _____

Phlebitis or blood clots . . . . . ☐ No ☐ Yes

What body part? _____

Pneumonia or lung infection . . . . . ☐ No ☐ Yes

Prostate enlarged . . . . . ☐ No ☐ Yes

Seizures . . . . . ☐ No ☐ Yes

Stroke . . . . . ☐ No ☐ Yes

When? _____

Thyroid disease . . . . . ☐ No ☐ Yes

What type? _____

Ulcers . . . . . ☐ No ☐ Yes

What type? _____

Varicose veins . . . . . ☐ No ☐ Yes

DO YOU NOW OR HAVE YOU EVER HAD... Notes / Explanations

EAR, EYE, NOSE, THROAT:

Any eye disease, injury, impaired sight? ☐ No ☐ Yes
Any ear disease, injury, impaired hearing? ☐ No ☐ Yes
Any trouble with nose, sinuses, mouth and/or throat? ☐ No ☐ Yes

CARDIO-RESPIRATORY:

Chronic or frequent cough? ☐ No ☐ Yes
Chest pain, pressure or discomfort? ☐ No ☐ Yes
Shortness of breath? ☐ No ☐ Yes
Palpitation or irregular heartbeat? ☐ No ☐ Yes

GASTROINTESTINAL:

Trouble swallowing? ☐ No ☐ Yes
Nausea or vomiting? ☐ No ☐ Yes
Black or bloody stools? ☐ No ☐ Yes
Constipation or diarrhea? ☐ No ☐ Yes
Rectal pain, swelling or bleeding? ☐ No ☐ Yes
Has there been a change in
Your appetite or eating habits? ☐ No ☐ Yes
Your bowel habits or stools? ☐ No ☐ Yes
Abdominal pain or swelling? ☐ No ☐ Yes
Weight loss? ☐ No ☐ Yes
Weight gain? ☐ No ☐ Yes

GENITO-URINARY:

Urinary frequency or burning? ☐ No ☐ Yes
Do you get up at night to urinate? ☐ No ☐ Yes
How many times? _____
Any difficulty in urinating? ☐ No ☐ Yes

EXTREMITIES:

Pain in leg or calf when walking? ☐ No ☐ Yes
Bone or joint swelling? ☐ No ☐ Yes
Swelling (Feet or Legs)? ☐ No ☐ Yes
Pain in legs at night? ☐ No ☐ Yes
Numbness (Arms or Legs)? ☐ No ☐ Yes
Weakness (Legs or Arms)? ☐ No ☐ Yes
Burning (Feet or Legs)? ☐ No ☐ Yes
Coldness (Hands or Feet)? ☐ No ☐ Yes

NEUROLOGICAL:

Temporary loss of vision? ☐ No ☐ Yes
Temporary numbness or weakness of face, arm or leg? ☐ No ☐ Yes
Trouble with speech? ☐ No ☐ Yes
Fainting or loss of consciousness? ☐ No ☐ Yes
Any recent development of headaches? ☐ No ☐ Yes
Dizziness or vertigo? ☐ No ☐ Yes

FAMILY HISTORY:

Has any blood relative ever had: WHO

Cancer? ☐ No ☐ Yes
Diabetes? ☐ No ☐ Yes
Bleeding disorder? ☐ No ☐ Yes
Vascular problems? ☐ No ☐ Yes
Heart disease? ☐ No ☐ Yes
Lung problems? ☐ No ☐ Yes

Do you use tobacco? ☐ No ☐ Yes
What type? _____
If yes, how much _____ day How long? _____ years
Have you ever? ☐ No ☐ Yes
When quit? _____
Do you drink? ☐ No ☐ Yes
If yes - how much? _____ How often? _____

Peachtree Vascular Specialists, P.C.

Medical Information/HIPAA Release Form

Name:_____ **Date of Birth:**_____

RELEASE OF INFORMATION

☐ **I authorize the release of information including the diagnosis, records, and examination rendered to me and claims information. This information may be released to: (check all that apply)**

☐ Spouse: _____

☐ Child(ren):_____

☐ Other:_____

**This Release of Information will remain in effect until terminated by me in writing.*

VOICE MESSAGES

In order to provide the highest standard of care, staff at PVS may call you regarding appointment reminders or follow up messages.

Where do you prefer to be called?

☐At home:_____

☐At work:_____

☐Mobile phone:_____

In the event that we are unable to reach you:

☐Leave a detailed message

☐Leave a message asking you to return our call

☐ _____

The best time to reach me is (day of the week)_____ between (time)_____

Signed:_____ **Date:**_____

Witness:_____ **Date:**_____

Peachtree Vascular Specialists, P.C.

Prescription & Pharmacy Information

Patients Name:

Date of Birth:

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone:

Do you use any of the following:

☐ **DaVita Pharmacies** **Phone Number:**

☐ **The VA** **Phone Number:**

☐ **Mail Order (Express Scripts, Optum Rx)** **Phone Number:**

☐ **NO PHARMACY IS USED**

Patient's Signature

Date

Peachtree Vascular Specialists, P.C.

APPOINTMENT POLICY

To all patients of Peachtree Vascular Specialists, P.C.,

Peachtree Vascular Specialists, P.C. strives to provide a **high standard of care for all patients.** To this end, it is imperative that patients allow us to evaluate them at specified intervals (appointment times) to monitor the effectiveness and safety of medications and treatment. Therefore, *we require our patients to keep the appointments they have scheduled or notify us at least 24 hours in advance.*

Your health and welfare are very important to us. In order to be able to provide you the highest standard of prescription medication refills, diagnostic testing, and monitoring of chronic and acute conditions, we must be able to depend on our patients to honor scheduled appointment times, or to provide us with a *minimum of 24 hours' notice when you cancel or change your appointment.*

Our attendance policy states that *any patient who fails to show for an appointment, or who cancels or changes with less than 24 hours notices for any 2 appointments within a 12 month period will be required to prepay in advance to be seen by a clinician*. Prepayments may be made via cash, money order, or credit or debit cards (Visa, MasterCard, or American Express). This prepayment is non-refundable if you do not keep this scheduled appointment.

We have implemented this policy to enable us to **better serve the medical needs of our patients**. If you have any questions about this policy, please contact Spring Embry, Practice Administrator at (770)996-9945.

Thank you,

Physicians and Staff

Peachtree Vascular Specialists, P.C.

Peachtree Vascular Specialists, P.C.

Patient Financial Policy

Thank you for choosing our practice! Our Vascular Surgeons and Interventional Radiologists are committed to the success of your treatment and care. If you have further questions about any of the policies listed below, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by: Cash, Check, American Express, Discover, VISA, and Mastercard

Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from you primary care physician – *this is also true for Medicaid HMO plans. It is the patient's responsibility to obtain a referral to be sent to our office at least 24 hours before scheduled appointment.*

Which Plans Do You Contract With?

We contract with all plans except: Kaiser (except for Kaiser Multi-Plan), Wellcare HMO, America Group, PeachState ****It is the patient's responsibility to verify coverage and plan participation**

What is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, which are outlined below.

If You Have	**You Are Responsible For…**	**Our Staff Will…**
Commercial Insurance (Also known as indemnity insurance or "80% / 20% coverage")	*For office services:* All applicable copays and deductibles will be required at the time of the office visit. *If the physician recommends a procedure:* We will estimate your coinsurance payment and provide this information to you. A deposit will be requested prior to scheduling the procedure.	Call your insurance company ahead of time to determine deductible and coinsurance amounts. File an insurance claim as a courtesy to you.
Contracted HMO & PPO plans	*If office services/tests are covered:* Obtaining a valid referral from your PCP. All applicable copays and deductibles are required at the time of the office visit. *If the physician recommends a procedure that is covered:* We will estimate your coinsurance payment and provide this information to you. A deposit will be requested prior to scheduling the procedure. *If the test or procedure recommended is not covered by the plan:*	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services. Explain your financial responsibility before any test or procedure is scheduled. File the insurance claim on your behalf.

	Payment in full is requested prior to the procedure.	
Non-Contracted and Out of Network Plans	*For office services:* Payment of unmet deductible and full visit charges will be required at the time of visit. *For tests and procedures:* We will estimate your payment and provide this information to you. A deposit will be requested prior to the procedure.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services. Explain your financial responsibility before any test or procedure is scheduled. File an insurance claim on your behalf.
Regular Medicare & Medicare Advantage Plans	*For office services:* Your Part B deductible (if it has not been met) will be required at the time of service. If you do not have secondary coverage, we will also require your coinsurance be paid. *For tests and Procedures:* We will estimate our coinsurance payment and provide this information to you. A deposit will be required prior to the procedure.	File the claim on your behalf, as well as any claims to your secondary insurance. Explain your financial responsibility before any test or procedure is scheduled.
Medicaid & Participating Medicaid HMO	*For office services:* Your copay will be required at the time of visit. *For tests and Procedures:* We will estimate your coinsurance payment and provide this information to you. A deposit will be required prior to the procedure.	File the claim on your behalf, as well as any claims to your secondary insurance. Explain your financial responsibility before any test or procedure is scheduled.
No Insurance	*For office services:* Payment in full is preferred at the time of the visit. *If you are unable to pay in full, we offer several alternative payment solutions that can be discussed with our billing specialist. *For tests and Procedures:* We will estimate your payment and provide this information to you. A deposit will be required prior to the procedure.	Work with you to arrange payment. Please ask to speak with a billing specialist if you need assistance.

Peachtree Vascular Specialists, P.C.

Written Financial Policy

Thank you for choosing Peachtree Vascular Specialists PC. Our Primary Mission is to deliver the best and most comprehensive care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

We accept the following payments:

- Cash, Check, American Express, Discover, Visa, or MasterCard
  - We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $1500 or more.
- Convenient Monthly Payment Plans[1] from Care Credit
  - Allow you to pay in smaller payments over time
  - No annual fees or pre-payment penalties

Please Note:

Peachtree Vascular Specialists PC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For larger, more comprehensive treatment plans of $1500 or more, a minimum non-refundable deposit of $150.00 (in addition to co-insurance) is required to secure your initial treatment appointment.

For patients with insurance, we are happy to work with your carrier to mazimize your benefit and directly bill them for reimbursement for your treatment[2].

A fee of $25 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Peachtree Vascular Specialists PC charges $25 for returned checks.

If you have questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

_____ _____

Patient, Parent, or Guardian Signature **Date**

_____

Patient Name (Please Print)

[1]Subject to Credit Approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier

Peachtree Vascular Specialists, P.C.

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your personal health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Alan Levy, M.D.
1035 SouthCrest Dr., Suite 250
Stockbridge, GA 30281 770-996-9945

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.
   Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

   OPTIONAL:
4. **Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

OPTIONAL:

5. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

7. **Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required By Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - maintaining vital records, such as births and deaths
    - reporting child abuse or neglect
    - preventing or controlling disease, injury or disability
    - notifying a person regarding potential exposure to a communicable disease
    - notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - reporting reactions to drugs or problems with products or devices
    - notifying individuals if a product or device they may be using has been recalled
    - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
    - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in the defense of medical professional liability claims asserted by patient, or in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made and effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe has resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena or similar legal process
    - To identify/locate a suspect, material witness, fugitive or missing person
    - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:

5. **Deceased Patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:

6. **Organ and Tissue Donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:

7. **Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use you PHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorizations satisfies the following: (i)the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from Improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law): and (C) adequate written assurances that the PHI will not be re0-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.
8. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect to President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Worker's Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Alan M. Levy, M.D.** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; 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. In order to request a restriction in our use or disclose of PHI, you must make your request in writing Alan M. Levy, M.D., Your request must describe in a clear and concise fashion:
    a. **The information you wish restricted;**
    b. **Whether you are requesting to limit our practice's use, disclosure or both; and**
    c. **To whom you want the limits to apply.**
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Alan M. Levy, M.D.** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. To request an amendment, your request must be made in writing and submitted to **Alan M. Levy M.D.**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend

information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment, or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Alan M. Levy, M.D.**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of this Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask our office to give you a copy of this notice at any time. If you fail, upon request, to obtain a paper copy of this notice, contact **Alan M. Levy, M.D. @ 770-996-9945.**
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services, to Region IV OCR, US Dept. HHS, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909 or by fax to 404-562-7881. Their phone # is 404-562-7886. To file a complaint with our practice, contact **Alan M. Levy, M.D.**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact this office's contact person, **Alan M. Levy, M.D. @ 880-996-9945.**

Peachtree Vascular Specialists, P.C.

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have received a copy of Peachtree Vascular Specialists, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient **Date**