HEART VEIN & VASCULAR

Heart Vein & Vascular LLC

B. Alex Vakili M.D, F.A.C.C, F.S.C.A.I

Integrative Cardiovascular Clinic

2170 W State Road 434 Suite 190
Longwood, FL 32779
Phone: 407-990-1921 Fax: 855-537-4411
E-Mail: Support@heartveinvascular.com
Web: www.heartveinvascular.com

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information.

At Heart Vein & Vascular LLC, we are required to keep your health information secure and confidential by law. Also, by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we do not use or disclose some or all your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you. You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like, and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter the earlier documents but will add new information. You have the right to receive a report of whom we disclose your information to. If our privacy and security measures or systems are breached in any way, we will notify you. You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint. Please contact our Privacy Officer, Nichole Richardson, (407) 990-1921, for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

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PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security (Last 4 Digits): XXX – XX - _____

Gender (circle one): M F Email Address: _____

Street Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Name of Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Phone #: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

DOES THE PATIENT CURRENTLY HAVE ACTIVE INSURANCE? Yes No

Insurance Name: _____ Policy #: _____ Group #: _____

Name of Insured: _____ Relationship: _____

* Primary Care Physician: _____ * Preferred Pharmacy: _____

* Pharmacy Location: _____ Pharmacy Phone #: _____

* How did you hear about us? _____

***As of February 2019, Dr Vakili no longer covers at South Seminole Hospital. For hospital or ER Admission, please go to Advent Health Altamonte and have them notify our office.**

Preferred Language: English / Spanish / Other _____

Ethnicity: Asian / African American / Hispanic / Middle Eastern / White / Other _____

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MEDICATION & ALLERGY RECORD

Patient Name: _____ DOB: _____ Date: _____

Allergies: _____

Prescription Name	Dose	Frequency	Notes

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE MEDICAL INFORMATION

Patient Name: _____ Date: _____

By signing below, I acknowledge that I have received a copy of the **Heart Vein & Vascular, LLC** Notice of Privacy Practices.

_____ _____
Patient or Representative Signature Patient or Representative Name (Printed)

I authorize **Heart Vein & Vascular, LLC** to share my medical information with the following persons:

First & Last Name	Relationship	Phone Number
First & Last Name	Relationship	Phone Number
First & Last Name	Relationship	Phone Number

This authorization will remain in effect from the date it is signed until I cancel it in writing.
By signing below, I acknowledge I have reviewed and understand this authorization form.

Patient or Representative Signature: _____

Patient or Representative Name (Printed): _____

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Patient Consent to Obtain Records

Patient Name: _____ Date: _____

DOB: _____ Social Security (Last 4 Digits): XXX – XX - _____

I authorize **Heart Vein & Vascular, LLC** to obtain my records in their entirety. I authorize the following physician(s) / hospital(s) to release my records in their entirety or as instructed below:

PLEASE SEND RECORDS TO OUR OFFICE VIA FAX OR MAIL BELOW

Heart Vein & Vascular
2170 W State Road 434, Suite 190
Longwood, FL 32779
[P] 407-990-1921
[F] 855-537-4411

Purpose of Disclosure:
Continuing care with another physician/hospital: _____ Personal Copy: _____ Other: _____

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing. However, if I do it will not affect any actions taken prior to receiving tile revocation.
3. This form is strictly voluntary, and I may refuse to sign this authorization.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, or if I ask for it. 7. I will receive a copy of this form after I sign it.

Patient or Representative Signature: _____ Date: _____

Patient or Representative Name (Printed): _____

Relationship to Patient: _____

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Patient Consent to Release of Records

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security (Last 4 Digits): XXX – XX - _____

I authorize **Heart Vein & Vascular, LLC** to release my records in their entirety to:

_____

_____

_____

Purpose of Disclosure:
Continuing care with another physician/hospital: _____ Personal Copy: _____ Other: _____

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing. However, if I do it will not affect any actions taken prior to receiving tile revocation.
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RELEASE OF INFORMATION AND PAYMENT TO PHYSICIANS

In order to submit a claim for payment for covered services, we must have authorization to release medical Information to your insurance carrier.

MEDICARE AND MEDICAID

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

ALL OTHER INSURANCE

I hereby authorize Heart Vein & Vascular, LLC to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I authorize Heart Vein & Vascular LLC, Babak Alex Vakili MD to use, disclose, and furnish my personal health information, including but not limited to information about the services rendered to me as may be requested by my insurance carrier or its intermediaries and to those providers of its treatment, payment, and health care operations and as described more fully in the Heart Vein & Vascular, LLC written Notice of Privacy Practices which I have been provided a copy of.

I further agree that I am responsible for paying any balances which remain after insurance payments have been made.

Patient or Representative Signature: _____ Date: _____

Patient or Representative Name (Printed): _____ Date: _____

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Cancellation/No-show Policy

Patient Name:_____ D.O.B:_____ Date:_____

1.Office Visits

Your appointment needs to be cancelled at least 48 hours prior to your appointment time. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment sufficiently ahead of time, you may be preventing another patient from getting much needed treatment. Also, a situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule. Therefore it is necessary for you to cancel any appointment within a reasonable timely period. Otherwise you will be responsible for the irrevocable costs associated with your appointment. Our no-show & cancellation policy is as follows:

You will be charged a $50 no show fee if you miss your regular office visit appointment & fail to cancel 48 hours prior. This will not be covered by your insurance.

2.Late Arrivals for Doctor Appointments

We understand that delays can happen; however, we must try to keep the other patients and providers on time.

If you are 15 minutes past your appointment time, we may have to reschedule your appointment depending on the doctor's schedule.

3.Hospital and Outpatient Procedures (Cath Lab)

These are expensive and multidisciplinary procedures that require coordination with your insurance company, multiple caregivers and auxiliary staff. These procedures require large blocks of the doctor and staff's time along with equipment that are reserved specifically for your care.

If your procedure is not cancelled at least 10 days in advance, you will be charged a $500 fee to cover these costs. This will not be covered by your insurance company.

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4.Vein Procedures (RFA's,Venaseal,Phlebectomy,Etc.)

These are expensive and multidisciplinary procedures that require coordination with your insurance company, multiple caregivers and auxiliary staff.Due to high demand for these procedures last minute cancellations can cause an issue with the schedule and with the company that performs them. We are responsible for these costs even if you do not show up for your appointment.

If your vein procedure is not cancelled at least 72 hours in advanced, you will be charged a $250 fee to cover the cost of the equipment and technician's time. This will not be covered by your insurance company.

5.Ultrasounds

Due to a high demand for testing, last minute cancellations can cause an issue with the schedule and with the company that performs these tests. We are responsible for these costs even if you do not show up for your appointment.

If your ultrasound is not cancelled at least 48 hours in advance, you will be charged a $75 fee to cover the cost of the equipment and technician's time. This will not be covered by your insurance company.

6.Stress Test

Stress Test require expensive medication with short expiration time that are ordered just for you.

If your stress test is not cancelled at least 7 days in advance, you will be charged a $250 fee to cover the cost of the radioisotopes (medication), technician's time and equipment. This will not be covered by your insurance company.

I have read and understood the Heart Vein & Vascular,LLC. cancellation & no-show policy fees. I hereby agree to abide by the policy and agree to pay any penalty/fees that may result as outlined in the policy.

Patient Signature:_____ Date:_____