Carolina Vein Center

Patient Information

Name: ______________________________________ Date: ______________________

Address: ____________________________________ Home Phone: ________________

City: ___________________ State: ____ Zip: ________ Work Phone: ________________

SS#: _________________ Marital Status: ___________ Occupation: ________________

Date of Birth: __________________________________ Cell Phone: ________________

Emergency Contact: ____________________________ **E-Mail:** ____________________

Emergency Contact's #: __________________________ Nickname: __________________

Would you like to receive emails with special offers from Carolina Vein Center? yes ______ no ______

Insurance Information

Primary Insurance: ______________________________ **Phone**:____________________

Policy Holder's Name: ______________________________ Relationship: _______________

Policy Holder's Date of Birth: _______________________ SS#: ______________________

Policy ID#: _______________________________________ Group #: ___________________

Secondary Insurance: ____________________________ **Phone**:____________________

Policy Holder's Name: ______________________________ Relationship: _______________

Policy Holder's Date of Birth: _______________________ SS#: ______________________

Policy ID#: _______________________________________ Group #: ___________________

Primary Physician Information

Name: ____

Address: ____

City: __________________ State: _____ Zip code: ________

Phone: ____________________ Fax: ____________________

Secondary Physician Information

Name: ____

Address: ____

City: __________________ State: _____ Zip code: ________

Phone: ____________________ Fax: ____________________

Referral Information

How did you hear about our office?
(check one)

__ Physician
__ Internet
__ Friend/Family
__ Mail
__ Dinner
__ Que Pasa
__ Other: ______________________

____
____
____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carolina Vein Center or my insurance company to release any information required to process my claims.

*Patient/Guardian signature*___________________________________ *Date* ____________________

To ensure continuity of care, please list ALL the doctors and specialists you currently see:

Physician Name: ____

Medical Specialty: ____

Address: ____

City: __________________________ State: ___________ Zip: ________

Phone: _________________________ Fax: __________________________

Physician Name: ____

Medical Specialty: ____

Address: ____

City: __________________________ State: ___________ Zip: ________

Phone: _________________________ Fax: __________________________

Physician Name: ____

Medical Specialty: ____

Address: ____

City: __________________________ State: ___________ Zip: ________

Phone: _________________________ Fax: __________________________

Physician Name: ____

Medical Specialty: ____

Address: ____

City: __________________________ State: ___________ Zip: ________

Phone: _________________________ Fax: __________________________

By signing below I am giving Carolina Vein Center permission to give medical information to the above listed physicians to ensure continuity of care.

____ ____________________________

Signature Date

Carolina Vein Center

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO A HEALTH CARE PROVIDER

Patient information:

Name of Patient________________________________ Date of Birth ___________

Address ____

City, State, Zip_________________________________

Name & address of physician or facility authorized to release information:

____

____

____

____

(fill in your doctor's address)

Please forward information to:

Carolina Vein Center
Lindy McHutchison, MD
5309 Highgate Drive
Durham, NC 27713
Phone: (919)405-4200 Fax: (919)405-4210

The information below will be used for patient care:

Please provide any medical records in which there is mention of **lower extremity circulation**, **varicose veins**, **venous insufficiency**, or any recommendation for the use of **compression stockings** or hose that may assist us in the evaluation and possible treatment of this patient's venous problem.

This authorization shall be in effect until the information has been forwarded as requested.

Rights of the patient:

I understand that my treatment will not be conditional upon signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the Carolina Vein Center. A revocation is not effective if the information has already been disclosed but will be effective upon receipt of written notification.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the Carolina Vein Center, 5309 Highgate Drive, Ste. 100, Durham, NC 27713.

_______________________________________ Date:_________________

Signature of Patient or Personal Representative

____

Description of Personal Representative's Authority (attach necessary documentation)

Carolina Vein Center

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name: ____

Patient Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

______________________________ ______________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- □ An emergency existed and a signature was not possible at the time.
- □ The individual refused to sign.
- □ A copy was mailed with a request for a signature by return mail.
- □ Unable to communicate with the patient for the following reason:

____

- □ Other: ______________________________________

____

Prepared By: ______________________________________

Signature: ______________________________________

Date: ______________________________________

CAROLINA VEIN CENTER
Authorization for Release of Information

Name of Patient: ______________________________ Date of Birth: __________________

I authorize Carolina Vein Center to release protected health information to the entities or individuals named below:

Give information to spouse: Yes ___ No ____ N/A ____
name of spouse: __________________________

Give information to a family member or friend, please list: ___________________________

Contact me at work: Yes____ No____ N/A ____

Carolina Vein Center will send correspondence regarding your condition and care to the referring or family physician as noted in your chart unless you check this line:
____ No please do not release info to family physician

Description of Information to be released to family or friend:
Financial/Billing: Yes ____ No ____

Medical information: Yes ____ No ____

Please list any restrictions regarding information to be released: _______________________

____

Rights of the Patient:
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Carolina Vein Center. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective immediately upon receipt of notification by Carolina Vein Center.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

____ Date __________________________
Signature of Patient or Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation)

CAROLINA VEIN CENTER

5309 Highgate Drive
Durham, NC 27713

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice by law. If the policy changes, the new notice will be effective immediately. A current copy will always be posted in our office and on our website (www.carolinaveincenter.com) or we will provide you the revised Notice upon your request.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we will disclose protected health information to other physicians when we have the necessary permission from you to disclose your protected health information. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who. at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This 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.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment and if we are unable to reach you, we may leave a message with another member of your household or on your voicemail. We may notify you by mail of a scheduled appointment, or of a missed appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment and services that may be of interest to you. We may also use and disclose your protected health information for other informational activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgement, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights
Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in your medical and billing records set for as long as we maintain the protected health information. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate all reasonable requests, at your expense. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record. We may deny your request for an amendment. If we deny your request for amendment, you may file a statement of disagreement with us. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

***You have the right to receive an accounting of certain disclosures** we **have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.*

You have the rieht to obtain a paper** copy **of this notice from us

3. Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
You may contact our Privacy Officer at (919) 405-4200.

This notice was published and becomes effective on **April 14, 2003.**