# Oracle Heart & Vascular Inc.

## New Patient Registration

### PATIENT DEMOGRAPHICS

| Last name: | First name: | Middle initial: |
|---|---|---|
| Address: Street | City | State / Zip |
| Birth date: / / | Social Security #: - - ; Sex: ☐M ☐F | Marital status: |
| Home phone: NOTE: Detailed messages may be left at this number. | Cell phone: NOTE: Detailed messages may be left at this number. | Email: |

☐ I would like to opt out from receiving emails. You will still receive emails pertaining/related to our secure Patient Portal

Race: ☐American Indian ☐Asian ☐Native Hawaiian/Pacific Islands ☐Black/African American ☐White ☐Hispanic ☐Other ☐Decline to specify

Ethnicity: ☐Hispanic or Latin ☐Non-Hispanic or Latin ☐Decline to specify

### MEDICAL

| Primary care provider's name: | Referring provider's name: | | |
|---|---|---|---|
| Allergies: | Shellfish Allergy: ☐yes ☐no | Iodine Allergy: ☐yes ☐no | IV Contrast Allergy: ☐yes ☐no |
| Pharmacy Name: | Pharmacy location/number: | | |

### IN AN EMERGENCY, PLEASE NOTIFY

| Name: | Phone: | Relationship: |
|---|---|---|

### INSURANCE INFORMATION

| Patient employment status: | Patient's employer: | |
|---|---|---|
| Prescription BIN#: | Prescription GRP#: | Prescription PCN#: |
| Prescription insurance plan (if applicable): | | |
| **Primary** insurance name: | | |
| Policy holder: ☐self ☐ other: | ID #: | Group #: |
| Policy holder DOB: / / | Policy holder SS#: - - | |
| **Secondary** insurance name: | | |
| Policy holder: ☐self ☐ other: | ID #: | Group #: |
| Policy holder DOB: / / | Policy holder SS#: - - | |

I, ________Patient Name (printed)________ have read, understand, and agree to be fully responsible for the information contained within Oracle Heart & Vascular's PATIENT DEMOGRAPHICS and INSURANCE INFORMATION as stated here.

Patient Signature ________________ Date ________________

## PATIENT MEDICATION LIST

Patient Name: ______________________________ Date of birth: ______ / ______ / ______

**You are welcome to provide your own list in place of this form.**

| Medication | Dose | Frequency |
|---|---|---|
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# Oracle Heart & Vascular Inc.

## Patient Financial Policy

The following information outlines Oracle Heart & Vascular's Patient Financial Policy to include the PATIENT FINANCIAL AGREEMENT and ASSIGNMENT OF BENEFITS which all outline your financial responsibilities and is an essential element of your care and treatment.

### PATIENT FINANCIAL AGREEMENT

As a new or existing patient of Oracle Heart & Vascular, we may request your current identification and a copy of your insurance card or benefit information at the time of visit and possibly upon every appointment.

All information provided to Oracle Heart & Vascular must be accurate and complete, as the contrary may result in a denial of your claim or a delay in payment and could result in your full financial responsibility.

If medical services are related to a work injury or auto accident, please provide all applicable group hospitalization; Health Maintenance Organization (HMO); Workers' Compensation; insurance carrier's name, address or other contact information at the time of visit. All other health care benefits ("Insurance Plan(s)") to which you may be entitled will also be required. If this, or other related information is not provided prior to or at the time of your appointment, you may incur all charges associated with your appointment.

If your insurance policy requires prior verification, referral(s) for services, or any other insurance policy coordination, it is your responsibility and must be provided prior to the time of your visit.

Verification may include coverage for services rendered within or outside of Oracle Heart & Vascular to include facilities/services such as, but not limited to: radiology, laboratory, physical therapy, hospitals, rehabilitation, etc.

Required referrals by your policy must be provided **prior to your visit** or could result in your appointment being rescheduled or an estimate of all charges for your office visit, may be required in advance of services.

If you have a high deductible policy or do not currently have insurance benefits, financial responsibility to pay an estimate of charges for your appointment is due in advance of services.

In the case of out of network/plan services, there may be reduced benefits and may require the payment of larger co-payment(s), co-insurance(s), or other charge(s).

Payment or arrangement for payment of all service(s), copay(s), deductible(s), and remaining balances are due at the time of service or upon receipt for payment. If you are unable to provide payment, your appointment may be rescheduled. We accept cash, check or credit card. All returned checks are subject to a **$25.00 fee**.

Appointment cancelation or rescheduling of appointments must be made 24 hours in advance. All missed appointments are subject to a **$25.00 charge**.

Appointment cancelation or rescheduling for diagnostic ultrasound test and nuclear stress tests must be made 24 hours in advance. All missed diagnostic ultrasound are subject to a **$100.00 charge**. All missed nuclear stress test appointments are subject to a **$280.00 charge**.

Failure to pay or delinquency on any balance remaining on your account may result in Oracle Heart & Vascular, Inc pursuing an outside collection agency. Costs associated with such collection efforts will become your responsibility and may include interest, rebilling fees, court costs, attorney fees, collection agency costs, etc.

All services provided by Oracle Heart & Vascular, Inc are considered medically necessary, if you fail to have a procedure performed or do not comply with your provider's medical advice, this may result in a void of your coverage by your insurance company. Should this occur, you may be required to pay outstanding balances on your account, after insurance has been processed.

Some insurance policies may or may not agree to the usual, customary, or reasonable charges for your local area and may not cover all services or might deny payment for services that have been approved in advance. It will remain your responsibility to pay resulting balances after insurance has been processed.

I, ______________________________________ have read, understand and agree to be fully responsible for the information contained within Oracle Heart & Vascular's PATIENT FINANCIAL AGREEMENT as stated here. I hereby assign payment(s), from my Insurance Plan(s) to Oracle Heart & Vascular Inc. (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to myself.

______________________________ ______________________________

Patient Signature Date

## ASSIGNMENT OF BENEFITS

I, ______________________________________ hereby authorize direct payment of medical benefits to Oracle Heart & Vascular, Inc. for payment toward my claim and the release of benefits or medical information necessary to pay any secondary insurance payer. This DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS authorization will remain in effect until cancelled by myself in writing. A copy of this authorization is as valid as the original document.

The direct payment hereby assigned and authorized includes any Insurance Plan benefit(s) to which I am otherwise entitled, including any major medical benefits otherwise payable to myself under the terms of my policy but is not to exceed the balance due to Oracle Heart & Vascular Inc. (or its affiliate), the independent contractor physicians and/or professional corporations for services I received during the applicable periods of medical care.

I understand that if my Insurance Plan(s) does not consider the services rendered during this visit and/or a covered service and/or they have not authorized this service that they will not pay for the services rendered. I agree to be fully responsible for payment and any remaining balances to Oracle Heart & Vascular Inc. for any services rendered if determined by my Insurance Plan(s) to be a non-covered service.

I understand that in the case of out of network/plan services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance, or other charge in the event my insurance plan(s) does not reimburse services provided.

I authorize the release of medical information necessary in order to obtain payment.

I authorize the release of medical information to the Health Care Financing Administration and its agents for information needed to determine my benefits.

I authorize Oracle Heart & Vascular, Inc to deposit checks received on my account when made out in my name.

I authorize Medicare benefit payment(s) to be made on my behalf to Oracle Heart & Vascular Inc. and authorize any holder of medial information to be released to the Centers for Medicare & Medicaid Services and its agents if needed to determine these benefits or the benefits payable for the related services.

In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignments.

If I am a Medicare recipient, Oracle Heart & Vascular will bill Medicare as well as my secondary insurance on my behalf.

I certify the information provided in this application for payment is correct, current, and that I am the policy holder or beneficiary of the insurance plan(s) listed on the Patient Demographics form I completed and signed.

I, ____________________________________________ have read, understand, and agree to be fully responsible for the information contained within Oracle Heart & Vascular's ASSIGNMENT OF BENEFITS as stated here.

______________________________________________________________ ______________________________

Patient Signature Date

______________________________________________________

Patient Medicare Number

| PATIENT AND PRACTICE RESPONSIBILITY SNAPSHOT | | |
|---|---|---|
| **If you have…** | **Patient responsibility…** | **Oracle Heart & Vascular responsibility…** |
| **Commercial Insurance** | All applicable copays are requested at the time of service | File the patient's insurance claim(s) |
| **HMO & PPO plans with which we have a contract** | All applicable copays are requested at the time of service | File the patient's insurance claim(s) |
| **HMO with which we are not contracted** | Payment in full for office visits and other charges at the time of service | Provide necessary information to complete and file claim(s) directly with insurance company |
| **Point of Service Plan or Out of Network PPO** | All applicable copays are requested at the time of service<br>Payment for all out of network benefit(s), and other charges are due at the time of service | Out of network benefit(s) or point of service plan(s), will be filed as an insurance claim on the patient's behalf |
| **Medicare** | If you have Medicare, no payment is required at the time of service | File the patient's claim(s), as well as any claims to secondary insurance plans<br>The patient's responsibility portion will be billed directly to the patient |
| **Medicare HMO** | All applicable copays are requested at the time of service | File the patient's claim(s), as well as any claims to secondary insurance plans |
| **Worker's Compensation** | If other arrangements have been made and verified in advance with patient insurance carrier(s), then no payment is necessary at the time of service<br>If eligibility is denied, payment in full will be required at the time of service | Gather basic accident details such as date of accident, claim number, primary care physician, employer information, and referral procedures |
| **Worker's Compensation (Out of State)** | Payment in full is requested at the time of service<br>File claims with insurance carrier | Provide the patient with a receipt for filing claims with insurance carrier |
| **No Insurance** | Payment in full is due at the time of service (please speak with our staff if you need assistance) | Provide financial assistance and options for the patient |

The following information outlines Oracle Heart & Vascular's Patient Confidentiality Practices and includes a SUMMARY OF PRIVACY PRACTICES, USES & DISCLOSURES OF HEALTH INFORMATION and PATIENT RIGHTS. This notice describes how medical information about you may be used and disclosed, as well as ways you may access your information personally.

## SUMMARY OF PRIVACY PRACTICES

We take very seriously the privacy of our patients and all health information that is private. The following information applies to all Protected Health Information (PHI) as defined by federal regulations. The proceeding pages describe our efforts to protect your PHI as well as information explaining your rights regarding your health information.

We are committed to protecting the privacy of information we gather about you while providing healthcare services. We further respect your discretion regarding the ways in which your information is shared with others. Except as described in this Notice of Privacy Practices and consistent with its legal obligations, our practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

In certain circumstances, we may change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made.

For additional information or questions, please contact:

**Kimberly Spring**
**Practice Administrator and Practice Privacy Officer**
**(855) 739-9953 (ex. 315)**

## USES & DISCLOSURES OF HEALTH INFORAMTION

**Treatment:** We use medical information about you to provide you with our professional services. We disclose medical information to our employees and others who are involved in providing the care you need. We may share your medical information with other physicians or other health care providers, as well as pharmacist(s) who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick, injured, incapacitated or if you are deceased. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. All our staff are required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or services to you. These professionals will have a privacy and confidentiality policy like this one. Health Information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Change of Ownership:** If this medical practice is sold or merged with another organization, your health information/record will become the responsibility of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

**Coroners:** We may, and are often required by law, to disclose your health information to coroners for their investigation(s) of death(s).

**Organ or Tissue Donation:** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition, or death. If possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions, or to lessen a serious and imminent threat to health or safety, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We may use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical device(s) and healthcare staff, billing, schedulers, patient satisfaction, and individuals performing similar functions. We may also use and disclose your information as

## USES & DISCLOSURES OF HEALTH INFORAMTION (continued)

necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "Business Associates," such as our EHR company, that provides IT support services for our electronic health records system. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services.

**Business Associates:** We will obtain written agreements, or contracts from “Business Associates” who may be a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information (PHI) on behalf of, or provides services to our practice. We require each of our Business Associate(s) to also sign a confidentiality agreement to safeguard any PHI received, created, or maintained by them on behalf of this practice. Their use and disclosure of PHI is limited to the minimum necessary required for the performance of their contracted activities. The terms of the contract we use conform to HIPAA requirements. We reserve the right to terminate any such agreement or contract if we have reason to believe that the Business Associate has breached or violated the terms of the contract.

**Reminders:** We may use or disclose your health information to provide you with reminders, including, but not limited to, voicemail messages, texts, emails, postcards, or letters.

**Marketing health-related services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**Payment:** We may use and disclose your health information to seek payment for service we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Workers’ Compensation**: We may disclose your health information as necessary to comply with workers’ compensation laws. For example, to the extent workers’ compensation covers your care, we will make periodic reports to your employer about your condition. Law also requires us to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Required by Law:** We may use or disclose your health information when we are required to do so by law for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Judicial and Administrative Proceedings:** We may, and are sometimes required by law, to disclose your health information during any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

**Public Health Responsibility:** We will disclose your healthcare information to report problems with products, reactions to medications, product recalls, disease/infection exposure, disaster relief, and to prevent and control disease, injury and/or disability.

## PATIENT RIGHTS

**Health Information**
Upon written request, you have the right to inspect and get copies of your health information. We will provide a copy or a summary and this can take up to 30 days from the time of your request. We may charge a reasonable, cost-based fee if applicable.

**Amendments**
You may submit a correction request regarding your health information that is inaccurate or incomplete. We will provide written or verbal notice within 30 days if your requests can not be fulfilled due to certain circumstances.

**Communications**
You may request a specific means of contacting you. For example, you may prefer to be reached by your cell phone only or office number or email.

**Protections**
You may request that certain health information for treatment, payment, or our operations not be shared. You may also ask us not to share information regarding services or health care items, that are paid for out-of-pocket, with your health insurer for payment or our operations. In some circumstances, we may not fulfill such requests, especially where compliance would affect the quality of your care or we are legally required to share that information.

**Disclosures**
You may request a list of instances in which we have disclosed your health information for purposes, other than treatment, payment, healthcare operations and other specified exceptions for the last six years. All additional requests will result in reasonable, cost-based fee.

**Notice**
You may request a paper copy of this notice at any time.

**Acting on your behalf**
If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**Complaint**
You may file a complaint to us directly if you believe your rights have been violated. Please contact us directly:

**Kim Spring**
**Practice Administrator**
**(855) 739-9953 ex315**
**kspring@magnusheart.com**

**Lori Reaves**
**Compliance Officer**
**(855) 739-9953 ex305**
**lreaves@magnusheart.com**

You may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
**200 Independence Avenue, S.W.**
**Washington, D.C. 20201**
**(877) 696-6775**
**www.hhs.gov/ocr/privacy/hipaa/complaints/**

## PRACTICE CONTACT INFORMATION

**1011 Care Way, Suite 200, Fredericksburg, VA 22401**
**fax: (877) 916-0801**

(855) 739-9953
www.OracleHeartVA.com

# Oracle Heart & Vascular Inc.

## Disclosure Authorization

The following form provides Oracle Heart & Vascular with the authorization to disclose your health information for the purposes of your care. This authorization includes your provision for us to speak with the emergency point of contact(s) or authorized entities listed below to discuss your care.

### PROTECTED HEALTH INFORMATION EXPLANATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law providing individuals with a new right to understand and control how their health information is used. The law further requires that your healthcare records and other identifiable patient health information (PHI) be confidentially maintained no matter their form – electronic, paper or spoken. HIPAA also requires that a ***Patient Confidentiality Practices*** be made available to you. This notice provides a clear explanation of your rights and our duties. Please request a copy from our front office staff if you wish to review it or have a copy.

To learn more about HIPAA, visit the United States Department of Health and Human Services website at: http://www.hhs.gov/ocr/privacy/hipaa/administrative.

I, ______________________________ understand that a copy of the ***Patient Confidentiality Practices*** is available for my review at www.oracleheartva.com and can be requested from the front desk staff.

______________________________ ______________

Patient signature Date

### AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMAITON

In signing below, you authorize Oracle Heart & Vascular Inc. to disclose your Protected Health Information (PHI), on your behalf and/or in your absence, and/or account records to the individual(s) or organization(s) listed below. Unless otherwise stated, **ALL** information may be disclosed or released to these individuals.

You may choose not to list individual(s)/organization(s) and you also have the right to revoke this authorization in writing at any time, accept to the extent that action has been taken in reliance of this authorization.

This authorization **DOES NOT** include Healthcare providers and professionals involved in your care as it is already protected through our Privacy Practice guidelines.

______________________________ ______________

First and last name of emergency contact Phone number

______________________________ ______________

First and last name of emergency contact Phone number

______________________________ ______________

Patient signature Date