MEMPHIS VASCULAR CENTER

6401 Poplar Ave Suite 505
Memphis, TN 38119

p. 901.683.1890
f. 901.334.5760
memphisvascular.com

# 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.

Memphis Vascular Center is required to maintain privacy of your health information, called protected health information or PHI. and to provide you with this notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We abide by the terms of this notice and will not use or disclose your health information without your authorization, except as described in this Notice. We reserve the right to change our practices and will provide you with a copy of the revised notice if we choose to do so.

**HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**
The following sections explain how we may use or disclose your PHI. Some of the uses and disclosures described may be limited or restricted by state laws or other legal requirements not listed.

For Treatment. Memphis Vascular Center will use your medical information for treatment purposes. An example is the information obtained by a nurse or a physician that will be recorded in your medical record. This information will be used by members of the healthcare team or may be shared with another physician who treats you to determine treatment and response for medical intervention.

For Payment. We may use or disclose your PHI in order to bill or collect payment for the services we provide to you. This may include disclosing appropriate medical billing information to a collection agency should efforts to collect from your insurance company or yourself become unproductive. We file insurance as a courtesy for patients, but the responsibility for payment is with the patient or the responsible party-as they are the policyholder.

For Health Care Operations. We may use and disclose your PHI in order to operate our practice. For example, we may use your PHI to manage your treatment and the services provided to you.

Individuals Involved in Your Care. Unless you notify us that you object, we may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location or general condition.

As Required by Law. We may use or disclose PHI about you when required to do so by federal, state or local law. We may also disclose PHI about you as required to comply with court orders, discovery requests or other legal process in the course of a judicial or administrative proceeding.

Law Enforcement. We may disclose PHI about you to law enforcement officials, when permitted or required by law.

For Public Health Activities. We may disclose PHI about you to government officials in charge of collecting information about reportable diseases or for other public health activities.

For Health Oversight Activities. We may disclose your PHI for oversight activities such as governmental oversight, licensure, auditing or other similar purposes.

For Research Purposes. In certain circumstances, we may use or disclose PHI in order to conduct medical research. We will almost always ask for your specific permission if the researcher has access to your name, address or other information that reveals who you are.

For Public Safety. If necessary, we may disclose your PHI to prevent or lessen a serious threat to the health or safety of a person or the public.

Government Functions. If you are a member of the armed forces, we may disclose PHI about you as required by military command authorities. We may disclose PHI about you to authorized federal officials for intelligence, counterintelligence, protection of the President, other persons or foreign heads of state and other national security activities authorized by law.

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Workers' Compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Organ and Tissue Donation. If you are an organ donor or potential recipient, we may disclose PHI about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Medical Examiners and Funeral Directors. We may disclose PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

Inmates. We may disclose PHI of an inmate or other person when required by a correction institution or law enforcement official for health, safety and security purposes.

Business Associates. We contract with vendors and service providers, called business associates, to perform on our behalf or assist us in the performance of functions or activities involving the use or disclosure of PHI. By law and under the terms of our contracts, our business associates are required to safeguard and protect your PHI.

**AUTHORIZATION**

Other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization. Uses and disclosures that require your authorization include any sale of your PHI and use or disclosure of your PHI for paid marketing purposes. If you authorize us to use or disclose your PHI for a purpose not described in this Notice, you may revoke the authorization in writing at any time, except to the extent your PHI has already been disclosed under the authorization.

**YOUR HEALTH INFORMATION RIGHTS**

The Right to Inspect and Copy. You have the right to inspect and obtain a copy of your PHI that we use to make decisions about your care or payment for your care, including in some cases an electronic copy, by requesting access in writing. We will charge $.25 per page for paper copies. We may also charge reasonable fees for the labor and supplies to create an electronic copy, if requested.

Right to Request Corrections. You may request in writing that we amend your PHI if you feel that information we have is incorrect or incomplete. We are not required to make your requested amendment in all cases, but you may ask that we include your request to amend when we disclose your information in the future.

Right an Accounting of Disclosures. You may request in writing that we provide a list accounting for how we have shared your PHI in the six (6) years prior to the date of your request. This accounting will not include disclosures we have made for treatment, payment, our health care operations, certain disclosures required by law or as specifically authorized by you.

Right to Request Restrictions on Disclosure. You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also may request that your health information not be disclosed to family members or friends who may be involved in your care. You must state the specific restriction requested and to whom you want the restriction to apply. This office is not required by law to agree to a restriction that you may request, except that we must agree to restrict disclosures of your PHI to your health insurer about a service or services for which you have paid us out of pocket in full.

Right to Request Confidential Communications. You may also request that we communicate with you about your health care using a certain means or at a certain location, such as a specific mailing address. Your request must be made in writing.

Right to Notification of a Breach. We are required to notify you of any breach of your unsecured protected health information that we discover.

Right to a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically. This Notice may be changed at any time.

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**TELEPHONE CONTACT, MESSAGES AND EMAIL**

From time to time, Memphis Vascular Center may need to contact you regarding the treatment we provide to you. If contacting you by telephone, we may leave a voicemail or message if you have given us permission to do so on the form you sign acknowledging receipt of this Notice. We may also use email to contact you if you have given permission on the acknowledgment form.

**FOR MORE INFORMATION**

If you have questions or would like additional information, please contact our Privacy Officer at (901) 683-1890. If you believe your privacy rights have been violated, you can file a complaint with our office.

Complaints may be addressed to:

**Kim Asher, Privacy Officer**
**6401 Poplar Ave Ste 220**
**Memphis, Tn. 38119**
**901-683-1890**
**asherk@medrad.net**

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services using the contact information provided below. There will be no retaliation against you for filing a complaint.

**EFFECTIVE DATE:** This Revised Notice is effective September 23, 2013

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# Your Rights and Protections against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

**WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?**
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

**EMERGENCY SERVICES**
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

**CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER**
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

**WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed,** you may contact Memphis Vascular Center at (866)885-7486 or (877)406-2976

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

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CHART #:_____ DATE: _____

## PATIENT INFORMATION

Home Phone: _____ Cell: _____ DOB: _____

Last Name: _____ First Name: _____ MI: _____

Address:_____ City:_____ ST: _____ ZIP:_____

Email Address: _____ SSN:_____

Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Referred By: ☐Physician ☐Friend/Relative ☐Emergency Room ☐Other: _____

Referring Physician:_____ Physician Phone:_____

Physician Address: _____ City:_____ ST: _____ ZIP:_____

Employer : _____ Employer Phone:_____

Employer Address:_____ City:_____ ST: _____ ZIP:_____

Emergency Contact: _____ Contact Phone: _____

Emg. Contact Address:_____ City:_____ ST: _____ ZIP:_____

## RESPONSIBLE PARTY

Last Name: _____ First Name: _____ MI: _____

Address:_____ City:_____ ST: _____ ZIP:_____

Home Phone: _____ Cell: _____ DOB: _____

SSN: _____

## INSURANCE INFORMATION

Primary Insurance Company:_____ Insurance Phone:_____

Policy Holder: _____ DOB: _____SSN:_____

Policy Holder Address: _____ City:_____ ST: _____ ZIP:_____

Policy No: _____ Group No:_____ Ref No: _____

Other Insurance:_____ Insurance Phone:_____

Policy Holder: _____ DOB: _____SSN:_____

Policy Holder Address: _____ City:_____ ST: _____ ZIP:_____

Policy No: _____ Group No:_____ Ref No: _____

**ASSIGNMENT OF BENEFITS:** I hereby authorize the verification of my medical benefits and payments directly to the treating physician. I understand that I am responsible for any portion of my bill not covered by my insurance company.

**RELEASE OF INFORMATION:** I hereby authorize the treating physician to release any information required in the course of my treatment to my insurance.

**GUARANTEE OF PAYMENT:** I understand that pre-authorization is not a guarantee of payment from the insurance company. Memphis Vascular Center (Memphis Radiological, P.C.) will bill for the services rendered, but I understand that any agreement is between my insurance company and me. If any amount due for the service rendered becomes delinquent and the debt is assigned to a third party for collections, it is understood that court costs, attorney's fees and other reasonable costs of collection may be added to the amount of the account.

SIGNATURE (Responsible Party): _____Date:_____

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## Physician Disclosure of Financial Interest

## For Patients Referred for Certain Imaging Services

Memphis Radiological Professional Corporation (MRPC) conducts its vascular and interventional radiology business using the name "Memphis Vascular Center," and MRPC owns and operates a diagnostic imaging facility called "Diagnostic Imaging". MRPC physicians may refer you for diagnostic imaging such as CT or MRI. You may choose to have your imaging at MRPC's Diagnostic Imaging facility located at 6401 Poplar Ave., Suite 100, Memphis, TN 38119 or at other facilities not affiliated with MRPC. The following are other radiology facilities within a twenty-five (25) mile radius of MRPC and Diagnostic Imaging:

East Campus Imaging Center
6555 Quince Road
Memphis, TN 38119
901-515-3600

Desoto Imaging Specialists
7420 Guthrie Dr. N
Southaven, MS 38671
662-349-4321

Total Care Imaging Center
6005 Park Ave
Memphis, TN 38119
901-765-1000

Park Ave Diagnostic Center
5190 Park Ave
Memphis, TN 38119
901-767-1015

The Imaging Center
7600 Wolf River Blvd # 100
Germantown, TN 38138
901-312-4033

By signing below, you acknowledge your receipt of this Physician Disclosure of Financial Interest and understand that your referring doctor is an owner of MRPC which owns and operates Diagnostic Imaging.

Patient Name (print): _____ Date: _____

Patient Signature (or legal representative): _____

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I, _____, (please print full legal name) have been shown the (Privacy Policy for this office), and have been offered a copy of such policy to keep for my records. I consent to receive phone calls and texts from or on behalf of Memphis Vascular Center, including those using automated dialing systems and/or an artificial or prerecorded voice, which may include, but are not limited to, appointment reminders, reminders to schedule wellness exams or other preventative services, payment-related messages, patient satisfaction surveys, and to receive information about the availability of new services.

I hereby give permission for this office to leave messages on the answering service, voicemail/email at:

_____My home (please initial)

_____My cell (please initial)

_____My office (please initial)

_____Email/text (please initial)

I hereby give the following people permission to receive information from this office on my behalf:

Name of Person:_____ Relationship to me: _____

Name of Person:_____ Relationship to me: _____

Name of Person:_____ Relationship to me: _____

Signature: _____ Date: _____

**NOTICE TO PATIENTS**

Memphis Vascular Center has a fee of $25.00 per request for completion of papers that include, but will not be limited to FMLA, Disability, and Third Party Insurance Companies making payment to patients. This fee may be paid either by check, credit card, or cash. Please make checks payable to MRPC. Forms will be completed upon receipt of payment.

**PLEASE ALLOW 5-7 BUSINESS DAYS FOR COMPLETION OF THIS PAPERWORK**

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# Patient Medical History

In a few words, why are you here today? _____

**Past Medical History - please check all that apply:**

- ☐ Anemia
- ☐ Arthritis
- ☐ Ascites/ Abdomen distention
- ☐ Asthma
- ☐ CAD (coronary artery disease)
- ☐ Cancer - type: _____
- ☐ Cerebral aneurysm
- ☐ Cirrhosis
- ☐ Clotting disorder
- ☐ Congestive Heart Failure (CHF)
- ☐ CVA (stroke)
- ☐ Defibrillator
- ☐ Depression
- ☐ Diabetes - type: ☐I ☐II
- ☐ Emphysema
- ☐ Encephalopathy/ confusion
- ☐ Endometriosis
- ☐ GERD (reflux disease)
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Hepatitis - type: ☐A ☐B ☐C ☐unknown
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ IBS - ☐Crohn's ☐ulcerative colitis ☐other: _____
- ☐ Kidney (renal) disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ PVD (peripheral vascular disease)
- ☐ Seizure disorder
- ☐ Stroke-like symptoms (TIA)
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Uterine fibroids
- ☐ Other: _____

**Surgical History - please check all that apply:**

- ☐ Appendix removed: _____
- ☐ Bladder suspension:_____
- ☐ Carotid endarterectomy: ☐L ☐R _____
- ☐ Carpel tunnel syndrome: ☐L ☐R ☐B _____
- ☐ Cataract: ☐L ☐R _____
- ☐ Cesarean section:_____
- ☐ Colon resection: _____
- ☐ Exploratory lap:_____
- ☐ Femoral bypass: _____
- ☐ Gall bladder removed: _____
- ☐ Heart bypass: _____ # of bypasses _____
- ☐ Hernia repair:_____
- ☐ Hysterectomy: ☐total ☐partial ☐vaginal _____
- ☐ IUD: _____
- ☐ Kidney removal: ☐L ☐R ☐B _____
- ☐ Knee replacement: ☐L ☐R ☐B _____
- ☐ LEEP: _____
- ☐ Liver resection: _____
- ☐ Mastectomy: ☐L ☐R ☐B _____
- ☐ Organ transplant - Organ: _____ _____
- ☐ Orthopedic surgery: _____
- ☐ Stents - List:_____ _____
- ☐ Thyroidectomy: ☐total ☐partial _____
- ☐ TIPS: _____
- ☐ Other: _____

Primary Care Physician: _____ PCP Phone: _____

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**Family History - please check all that apply and list the family member(s) that condition applies to:**

- ☐ Unknown Family History
- ☐ Aneurysm: Family: _____
- ☐ Cancer: Type:_____ Family: _____
- ☐ CVA: Family: _____
- ☐ Diabetes: Family: _____
- ☐ Heart Attack: Family: _____
- ☐ High blood pressure: Family: _____
- ☐ High cholesterol: Family: _____
- ☐ Osteoporosis: Family: _____
- ☐ Seizure disorder: Family: _____
- ☐ Sudden cardiac death: Family:_____
- ☐ Vascular disease: Family: _____
- ☐ Other: _____ Family: _____

**Social History - please check all that apply:**

Tobacco Use: ☐ Non-smoker ☐ Smoker ☐ Dip ☐ Chewing Tobacco
How many packs per day:_____
How many years: _____
Quit date: _____

Alcohol Use: ☐ Non-drinker ☐ Socially ☐ Daily

Illegal Drug Use: ☐ Yes ☐ No Please List:_____

Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Widowed

Employment: ☐ Full time ☐ Part Time ☐ Retired ☐ Unemployed
☐ Other: _____
Occupation: _____

Pharmacy you prefer: _____ Phone:_____

**Medication History - please list any medications you are currently taking and why:**

Name of Medication: _____ How often: _____ Dose: _____
Name of Medication: _____ How often: _____ Dose: _____
Name of Medication: _____ How often: _____ Dose: _____
Name of Medication: _____ How often: _____ Dose: _____
Name of Medication: _____ How often: _____ Dose: _____
Name of Medication: _____ How often: _____ Dose: _____
Name of Medication: _____ How often: _____ Dose: _____

Allergies to Medications:_____

Height: _____ Weight: _____ Do you have an Advanced Care Plan or Surrogate decision maker?: ☐ Yes ☐ No