SOUTH FLORIDA VASCULAR ASSOCIATES
Leading Change in Vascular Care

HIPAA Consents and Acknowledgements

Patient Name:_____Date of Birth: _____

Medical History

The information that I have provided to the staff is an accurate and current profile of my medical history and review of systems. I have disclosed all of my medical history known to me.

Consent to Leave Message:

I wish to be called at home _____ cell _____ regarding my care and follow-up.

I give permission to leave relevant medical information on my answering machine or voicemail. Yes___ No___

I authorize the following individual(s) to discuss my pertinent medical information:

_____

_____

Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Release of Information

I hereby authorize any physician, hospital, or medical facility to provide on my behalf all information on my medical history and treatment of the doctors at South Florida Vascular Associates. I hereby authorize South Florida Vascular Associates to release any information acquired in the course of my examination for the continuation of my treatment and care.

I have read and understand the above statements and agree to abide by the office policies outlined above. I hereby authorize a photocopy of the form to be as valid as the original.

Patient Signature:_____ Date:_____

William Julien, M.D Manwant Khatkar, PA Anissa Rodriguez, ARNP

7545 W. Boynton Beach Blvd, Suite 206 Boynton Beach, FL 33437 Tel: (954)725-4141 Fax: (954)725-4318

5300 W Hillsboro Blvd, Suite 107 Coconut Creek, FL 33073 Tel: (954) 725-4141 ▪ Fax: (954) 725-4318

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SOUTH FLORIDA VASCULAR ASSOCIATES
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.

This notice takes effect on 08/06/2020 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR INSURANCE & CREDIT CARD PAYMENT: We may use or disclose health information about you in order to bill and collect payment for the services and items you may receive from us.

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Office Policy for Financial Arrangements & Medical Insurance

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits.

- **Payment for service is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover & American Express.**
- **Filing of Insurance**
    1. **Surgery and diagnostic procedure**- As a courtesy to you, we will assist with your insurance for surgeries and diagnostic procedures. We will call to confirm benefits and when necessary written pre-authorizations will be prepared by our office. Insurance providers do not "guarantee" the amounts quoted over the phone. We must emphasize that as a medical provider, our relationship is with you; not your insurance company. Your active participation is necessary when denials occur or payments are delayed from your insurance provider. We will file claim forms with your primary insurer and you will be responsible for handling any secondary insurer.
    2. **Medicare**- Claim forms for covered Medicare procedures will be handled by the office.

- **Referral Policy**

  If you have HMO insurance coverage, your **referral must be in our office before your visit**. If our office does not receive a valid referral before your visit, you will have to reschedule your appointment.

  THIS IS YOUR RESPONSIBILITY!!!!!

  You can have it faxed to our office. You must check with our office to see that we have received the referral one day in advanced of your visit. Statements by the primary physicians' office that the referral was faxed or will be faxed do not guarantee that we will receive the fax.

  Please be aware that many of the Primary Care Physicians' offices have their own policies regarding the issuance of referrals. Some require 5-7 days of advance notice. Others require re-evaluation by the primary physician prior to a request consultation.

As the Patient you have the ultimate financial responsibility: All charges are expected at the time services are rendered by this practice. In the case that private insurance may pay a portion of your charges, your estimated payment (considering expected insurance coverage) will be required to be paid at the time of service. In the event that your insurance provider denies payments or pays less than expected, you are ultimately responsible for all balances on accounts. The Insurance Company's decisions and payment amounts are not within our control; however, we are happy to assist you in the insurance appeal process. In the event of an unpaid account by your insurance provider, please understand that you are ultimately responsible for all charges. If it becomes necessary to collect you unpaid account using a collection agency, you will be responsible for any charges incurred as a result of involvement of the collection agency/ attorney (usually 20-50% of unpaid amount) and any other legal or court fees incurred as a result.

Missed or Cancelled Appointments: The timeliness of treatments is important in getting the most effective results. We accommodate patient schedules as best we can. In consideration of this and other patients, this office requires a 48-business hour notice of cancellation of an appointment. This provides time to work other patients into the schedule. Failure to provide notice will result in a missed appointment charge ranging from $50 to $200 depending on the type of appointment that was scheduled. If you are more than 5 mins late to your appointment, you will be considered a No Show, and will be charged. Multiple late cancellations and or no show appointments may result in being discharged from the practice. These policies are strictly enforced.

Returned Checks A $25 service fee will be charged for all returned checks. Repayment will need to be cash, money order or credit card only.

I authorize this practice to provide any medical information about me to Medicare and/orinsurance providers in order to determine payment for services received from South Florida Vascular Associates.

Agreement

I, (print name)_____, have read and understand the cancellation policy and the terms & conditions of my financial obligation and agree to abide by the office policies outlined above.

Patient Signature:_____ Date: _____

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