Stuart Cardiology Group

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Norman E. Bennett, MD, FACC
A. James Bradley, MD, FACC
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Kristen Kumar, MSN, ARNP

Practice Limited to Cardiovascular Disease, Including Cardiac Catheterization and Interventional Cardiology

Patient's Name: _____ Social Security: _____-_____-_____

Sex: M F Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Secondary Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternative Phone: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Next of Kin: _____ Relationship: _____ Phone:_____

Primary Insurance: _____ Ins. ID No: _____ Group No. _____

Insured's Name: _____ Insured's Date of Birth: _____

Secondary Insurance: _____ Ins. ID No: _____ Group No. _____

Insured's Name: _____ Insured's Date of Birth: _____

I authorize Stuart Cardiology Group, PA to release my protected health information to the following people on my behalf.

Name	Relationship	Phone Number

Please provide insurance cards and driver's license to the receptionist so that we can scan them into our computer system for future reference.

I authorize any holder of medical or other information about me to release same to the Social Security Administration and Center for Medicare and Medicaid Services (CMS, formerly HCFA) or its intermediaries or carrier, the minimum necessary information needed for this or a related insurance or Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to insurance or Medicare assignment of benefits apply. I attest that the insurance information that I am providing is true and accurate. If this information is found to be false, I will be responsible for payment of all services rendered.

I also authorize the transfer of my Protected Health Information (PHI) to others for the purposes of "treatment" to be "electronically" transmitted on my behalf, including but not limited to fax, mail, e-mail, or via computer database.

If you must cancel an appointment with our office, we ask that you notify us 24-48 hours in advance. There is a $50.00 fee for "No Shows' on a Routine visit and a $100.00 fee for a 'No Show' for Nuclear Testing. These fees are due prior to scheduling your next appointment.

I also acknowledge that I have been provided the Notice of Privacy Practices, as well as the Patient Responsibility and Accountability Contract.

I further acknowledge that I am responsible to uphold all SCG policies. This signed receipt will become a permanent part of my medical record.

The doctor-patient relationship is based on trust and open communication. In order for your physician to make valid diagnosis and render beneficial care, the information you provide to him/her must be complete and true.

Signature:_____ Date:_____

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Medical History

_____ _____ _____ Date of Birth_____
First Name Middle Name Last Name

Reason for Visit: (Chief symptoms or reason why you were referred): _____

Cardiac Symptoms: Do you have or have you ever had…

	Yes	No	If Yes, when (date)
Chest pain or chest discomfort?	_____	_____	_____
Shortness of breath?	_____	_____	_____
History of congestive heart failure?	_____	_____	_____
Dizziness?	_____	_____	_____
Fainting?	_____	_____	_____
Near fainting?	_____	_____	_____
Palpitations/heart fluttering?	_____	_____	_____
Swelling in legs?	_____	_____	_____
History of heart attack?	_____	_____	_____
Previous bypass surgery?	_____	_____	_____
Valve surgery?	_____	_____	_____
Defibrillator (AICD)?	_____	_____	_____
Pacemaker?	_____	_____	_____
Angioplasty?	_____	_____	_____
Prior heart catheterization?	_____	_____	_____
Prior stress test?	_____	_____	_____
High blood pressure?	_____	_____	_____
Diabetes?	_____	_____	_____
High cholesterol?	_____	_____	_____
History of stroke?	_____	_____	_____
Pain in legs while walking?	_____	_____	_____

Family History of Heart Attack:	Yes	No	If Yes, Age of person
Mother	_____	_____	_____
Father	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____

Previous Surgeries: Date

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____

_____Initials

Review: Have you had…	Yes	No	If Yes, when (date)
Weakness?	_____	_____	_____
Fatigue?	_____	_____	_____
Recent fever or chills?	_____	_____	_____
Skin:	Yes	No	If Yes, when (date)
Rash?	_____	_____	_____
Psoriasis?	_____	_____	_____
Skin cancer removed?	_____	_____	_____
Bruising?	_____	_____	_____
Head, Ears, Eyes, Nose & Throat:	Yes	No	If Yes, when (date)
Thyroid problems?	_____	_____	_____
Cataracts?	_____	_____	_____
Glaucoma?	_____	_____	_____
Headaches or migraines?	_____	_____	_____
Sinus problems?	_____	_____	_____
Hoarse voice?	_____	_____	_____
Chest & Lungs:	Yes	No	If Yes, when (date)
Shortness of breathe?	_____	_____	_____
Wheezing, asthma, emphysema?	_____	_____	_____
Cough?	_____	_____	_____
Bronchitis?	_____	_____	_____
Pneumonia?	_____	_____	_____
Tuberculosis?	_____	_____	_____
Urinary Tract:	Yes	No	If Yes, when (date)
Kidney stones?	_____	_____	_____
Bladder infection?	_____	_____	_____
Kidney infection?	_____	_____	_____
Prostate problems?	_____	_____	_____
Difficulty urinating?	_____	_____	_____
Frequent urination?	_____	_____	_____
Painful urination?	_____	_____	_____
Stomach & Intestines:	Yes	No	If Yes, when (date)
History of Ulcers?	_____	_____	_____
Blood in stool?	_____	_____	_____
Gallstones?	_____	_____	_____
Hepatitis or jaundice?	_____	_____	_____
Hiatal hernia?	_____	_____	_____
Heartburn or acid reflux symptoms?	_____	_____	_____
Difficulty swallowing (food getting stuck)?	_____	_____	_____
Painful swallowing?	_____	_____	_____
Abdominal pains/stomach pains?	_____	_____	_____
Colon Polyps?	_____	_____	_____
Hemorrhoids?	_____	_____	_____
Nausea or vomiting?	_____	_____	_____
Diarrhea?	_____	_____	_____
Constipation?	_____	_____	_____

_____Initials

Diverticulitis (inflammation)?	_____	_____	_____
Diverticulosis (no inflammation)?	_____	_____	_____

Muscles & Bones:	Yes	No	If Yes, when (date)
Joint aches or pains?	_____	_____	_____
Arthritis?	_____	_____	_____
Back pain?	_____	_____	_____
Gout?	_____	_____	_____

History of Cancer:	Yes	No	If Yes, when (date)
If yes, what type?	_____		

Neurologic:	Yes	No	If Yes, when (date)
Seizure disorder, epilepsy?	_____	_____	_____
Difficulty walking?	_____	_____	_____
Are you unsteady on your feet?	_____	_____	
Do you use a walker or a cane?	_____	_____	

Pharmacy Information

Pharmacy Name _____ Phone: _____

Address _____ Fax: _____

Current Medications:

Name of medication	Dosage	How often
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____

Allergies:

Medication/Food/Item Allergic:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____Initials

Social & Family History

1. Marital Status
   ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Previously Widowed

2. Children ☐Yes ☐ No
   a. If yes, how many? Sons _____ Daughters _____

3. Race
   ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
   ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ White

4. Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino

5. Diet
   ☐Regular ☐Low Fat/Low Cholesterol ☐ Low Salt ☐No Salt Added ☐Diabetic ☐Renal ☐Weight loss ☐Vegetarian

6. Exercise
   ☐ Regular – *walking biking for 20 minutes, 3 or more times a week* ☐ Sedentary ☐ Occasional ☐ Aerobic ☐ Active Lifestyle ☐ Physically unable to exercise

7. Tobacco Usage ☐ Yes ☐ No ☐Former
   If Former: Year Stopped? _____ How many years did you smoke? _____ How many packs per day? _____

8. Alcohol
   How Often? ☐ Frequently ☐ Daily ☐ Social ☐ Rarely ☐ Don't Drink ☐ Former: Year Quit _____

9. Caffeine ☐Yes ☐ No
   If yes, type (check all that apply): ☐ Chocolate ☐ Coffee ☐ Tea ☐ Soda ☐ Tablets

10. Drug Use/Abuse ☐ Yes ☐ No ☐Former

11. Advanced Directives
    - None
    - Living Will - *States in advance a person's desire to receive, or to withhold, life-support procedures. This is put into use if someone becomes permanently unconscious or terminally ill and unable to make decisions.*
    - DNR – Do Not Resuscitate - *Written instructions to healthcare providers not to perform CPR if a person experiences cardiac or respiratory arrest.*
    - HC Proxy – *A person to make health care decisions for you when you are no longer capable of making them for yourself, or if you are unable to communicate your decisions to others. Your representative must be at least of the age of majority for your jurisdiction, and should be someone you have spoken to about your wishes.*

12. Primary Language: _____ Religion: _____

13. Residence
    ☐ Lives Alone ☐ Lives with Spouse ☐ Lives with Family Member ☐ Nursing Home ☐ Assisted Living

14. Employment: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Active Military ☐ Disabled ☐ Retired
    Employer: _____ Work Number: _____
    Occupation (In three words or less): _____ (i.e. Program Manager IBM)

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Records Request

I, the undersigned patient or legal representative, hereby authorizes Stuart Cardiology Group, PA to request any health information, including the diagnosis and records of any treatment or examination rendered to me.

Patient Name: _____ Date of Birth: _____

PLEASE PRINT CLEARLY

OFFICE USE ONLY: This information may be disclosed to and used by the following:

Name: **Stuart Cardiology Group, PA**
Address: **1001 SE Monterey Commons Blvd, Suite 300**
Stuart, Florida 34996

Phone Number: 772-286-9400 Ext: _____ Fax Number: _____

The dates of service and the type(s) of information to be used or disclosed are as follows:

DATE(S) OF SERVICE: _____
RECORDS REQUESTED:_____

This request is for the purpose of treatment, payment, and/or Health Care operations.

This authorization will be valid while I am a current patient with Stuart Cardiology Group, PA. I understand that I may revoke this authorization at any time by notifying Stuart Cardiology Group, PA in writing, but if I do it will not have any effect on actions that Stuart Cardiology Group, PA took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that I may inspect or copy the information to be used or disclosed.

Signature of Patient or Legal Representative: _____

Date: _____Address: _____

If signed by a Legal Representative, indicate your relationship to the patient below and provide appropriate documentation to verify your authority:

□ Parent □ Guardian □ Conservator □ Executor of Estate □ Power of Attorney □ Other

_____Initials

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Out of Network Benefits

As a patient, it is in your best interest to know if your plan is contracted with Stuart Cardiology Group, and to understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. You may have different deductibles, co-insurance, or co-payment amounts, depending on the contracted status of your insurance company.

If the physicians are not listed as a contracted provider and/or are not in your insurance company's network, we are still happy to file your insurance and provide you with services. If your policy has out-of-pocket benefits, your insurance plan may still cover services provided to you at Stuart Cardiology Group. However, you may be responsible to pay a higher amount out-of-pocket than if you receive services from an in-network provider. Your insurance company's customer service representative can help you verify your benefits and out-of-pocket cost; we con provide you with financial assistance options.

A LISTING IN AN INSURANCE HANDBOOK OR ONLINE IS NOT A GUARANTEE THAT WE ARE PROVIDERS. Not all services are covered in all insurance contracts. If your insurance plan benefits do not cover a service or procedure, you can be held personally responsible for payments of these charges. To find out what your insurance plan benefit covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are listed on your insurance card). Your employer's human resources department may also be a source of information and assistance.

_____ _____

Date Date of Birth

_____ _____

Print Name of Patient/Responsible Party Signature Name of Patient/Responsible Party

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Patient Responsibility & Accountability Contract

At Stuart Cardiology Group (SCG), in order to meet the basic requirements necessary to maintain doctor-patient relationships, we must hold our patients accountable. Please read the following policies carefully, and initial on each line to verify that you have read and understand your responsibilities as a patient. Failure to uphold any portion of this contract may result in immediate termination from care at SCG.

I, (print name) _____DOB_____, hereby consent to be examined by the medical staff at SCG and to be tested and treated as deemed necessary and appropriate by them.

_____ I agree to pay my co-payment, based on my insurance plan, at the time of each appointment.

_____ I agree to update my Patient Information Form and insurance documentation as required by SCG.

_____ I understand that any three (3) missed appointments within a 12 month period may disqualify me for services at SCG. I agree to call at least 24 hours in advance, if I need to cancel or reschedule an appointment.

_____ I understand that it is my responsibility to arrive on time (standard procedure is to arrive 15 minutes early) for my appointments. I understand that my appointment may be rescheduled, if I arrive late. (At the physician's discretion)

_____ I agree to contact my local pharmacy when I have 5 days of medication remaining. This allows your Provider to process your refill in a timely manner.

Patient Signature: _____Date:_____

SCG Representative:_____Date:_____

1001 SE Monterey Commons Blvd., Suite 300, Stuart, FL 34996 •
1945 SE Port St. Lucie Blvd., Port St. Lucie, FL 34952
10050 SW Innovation Way., Suite 202A Port St. Lucie, FL 34987
Phone: 772-286-9400 • Fax: 772-283-3832

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Our Financial Policy

1. *Why the policy is now in writing?*
   This is the financial policy of Stuart Cardiology Group. The purpose of this document is to communicate an expectation for

2. *Why we need to update personal information?*
   On an annual basis, we ask that you update your personal information. This helps us to keep current with any changes in demographic data or insurance information that may be pertinent.

3. *Initial office visit – What payment is required?*
   Prior to your first visit with us, we will verify your insurance to assure that we are a member of the plan under which you are covered. We will then communicate to you and your responsibility.

4. *Office policy on insurance assignment.*
   We are Medicare provider Physicians. Upon remittance from Medicare, you will be responsible for any deductibles or co-insurances due.

5. *Allowable forms of payment.*
   Stuart Cardiology Group accepts the following: cash, checks, debit cards, Visa, MasterCard, Discover and American Express.

6. *Cancellation of appointment policy and charges.*
   We request at least 24 hours' cancellation notice prior to your appointment .This allows another patients who may be ill to take your slot. Cancellations that continue to occur may result in you being charged for that appointment.

7. *Patient is responsible for appropriate charges.*
   We do not look to a third party for payment. Co-pays must be paid at the time of the visit. Deductibles and your co-insurance must be paid immediately upon notice form your insurance company.

8. *Maximum number of payments allowed.*
   Special payment arrangements for patients who do not have insurance may be made prior to him/her having diagnostic testing or seeing a Physician. Patients without insurance may receive a 25% prompt-payment discount on diagnostic testing, if charges are paid in full at time of service.

9. *Insufficient-funds on a check.*
   A charge of $38.00 will be made for insufficient-funds.

10. *Collection Policy*
    Any account turned over to collections will have a $25.00 collection fee added to the outstanding balance.

To discuss any aspect of our financial policy, you may contact the Billing Manager or the Practice Administrator with concerns of questions at any time.

_____ _____

Signature of responsible party Date

NOTICE OF PRIVACY PRACTICES
STUART CARDIOLOGY GROUP, P.A.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: September 23, 2013
This Notice was revised on September 20, 2013
IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:
Cynthia L. Schiefer, CMPE, Executive Director
1001 SE Monterey Commons Blvd. Suite 300, Stuart, FL 34996
772-286-9400
772-283-3832
info@stuartcardiology.com

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to

ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure 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. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** 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.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to a Summary or Explanation.

We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

Right to an Electronic Copy of Electronic Medical Records.

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such

information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do 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.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. However, if we are contracted with your health plan we will not take out-of-pocket payments for services rendered as this would be a breach of our contract with the insurance provider.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website. www.stuartcardiology.com