Heart & Vascular Associates of Augusta, P.C.

820 St. Sebastian Way, Suite 2A • Augusta, Georgia 30901

(Please check which Doctor)

❑ Dr. Weems Pennington, Jr. ❑ Dr. Bimal Shah ❑ Dr. John Salazar

Name: ______________________ SSN: ______________________

Sex: ________ DOB: _____ / _____ / __________ Email: ______________________

Mailing Address: ______________________

STREET OR P.O. BOX CITY STATE ZIP COUNTY

Phone Numbers: ______________________

HOME WORK MOBILE

Language: ______________ Need Interpreter: ❑ Yes ❑ No Marital Status: ❑ S ❑ M ❑ D ❑ W

Religion: ______________ Race: ______________ Ethnicity: ❑ Hispanic or Latino ❑ Prefer not to answer

Preferred Lab: ______________________

NAME STREET CITY STATE

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize examination and treatment by Heart & Vascular Associates of Augusta, P.C. I authorize release of medical information to insurance carriers necessary to process claims and assign to the physician payments for medical services. I understand that it is my responsibility to remit payment for charges not covered by my insurance company. I understand that it is my responsibility to see that all claims, precertifications, and authorizations are complete by my insurance company, since I am responsible for all professional services rendered to myself and/or dependent.

SIGNATURE: ______________________ Date: ______________

MEDICARE PATIENTS ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related 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 Medicare assignment of benefits apply.

SIGNATURE: ______________________ Date: ______________

NOTICE OF PRIVACY PRACTICES & NOTICE OF INDIVIDUAL RIGHTS

The Federal Government has passed a new law to assure the privacy of your medical information. All medical practices, hospitals and other medical providers are required to follow this new law to make sure your information is protected. It mainly pertains to protecting your information during the electronic insurance claims process but it also provides greater rights to the patient to direct where his or her medical information may be provided. We have always respected your privacy and will continue to do so in the future.

We have provided a notice to you describing how your medical information may be used and disclosed. As required by law, will you please sign your name on the line below to show that you have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient Signature : ______________________ Date: ______________

Printed Patient Name: ______________________

SEE OTHER SIDE ➡

Patient Name: ____________________

Nursing Home: ____________________

Primary Care Physician: ____________________
NAME STREET CITY STATE PHONE

Emergency Contact: ____________________
NAME RELATIONSHIP TO PATIENT HOME PHONE CELL PHONE

Patient Employer: ____________________
NAME ADDRESS CITY/STATE/ZIP PHONE

Employment Status: ❑ Full-time ❑ Part-time ❑ Disabled ❑ Retired ❑ Student ❑ Self Employed

Is visit accident related? ❑ Yes ❑ No Referred by: ____________________

RESPONSIBLE PARTY – GUARANTOR

❑ Same as above (self) ❑ Spouse ❑ Parent ❑ Other

Name: ____________________ SSN: ____________________ DOB: ____ / ____ / ______

Address: ____________________
STREET CITY STATE ZIP COUNTY

Guarantor's Employer: ____________________

INSURANCE INFORMATION

Primary Insurance: ____________________ Policy#: ____________________

Policy Holder: ____________________ Policy Holder Date of Birth: _____ / _____ / ______

Relationship to Patient: ____________________ Policy Holder SSN#: ____________________

**Secondary Insurance: ____________________ Policy#: ____________________

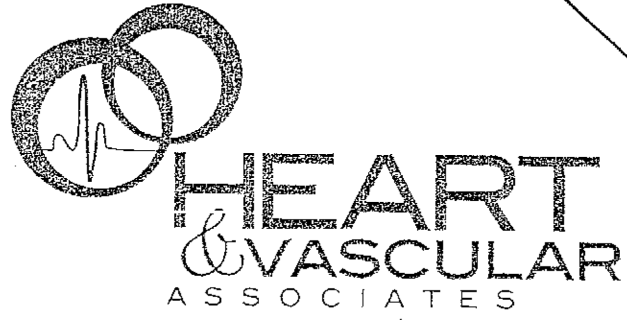
Policy Holder: ____________________ Policy Holder Date of Birth: _____ / _____ / ______

Relationship to Patient: ____________________ Policy Holder SSN#: ____________________

*****If there is a third insurance, please write on separate sheet of paper and attach to this form.**
WE WILL NEED A COPY OF ALL INSURANCE CARDS AND A PHOTO ID

Patient Parking Map

Harper Street
HVAA
Human Resources
Credit Union
To 15th Street
Saint Sebastian Way
Professional Center 1
Professional Center Parking Garage
C
Park
Parking for Heart & Vascular Institute/ Weight Management/ Bariatric Surgery and Advanced Heart Failure Center
E
Heart & Vascular Institute
Emergency Care Parking
D
Emergency Care
Main Hospital
Outpatient Center and Lab
Professional Center 2
Day Surgery Center
The Imaging Center
The Breast Center
R.A. Dent Boulevard
Caring Lane
Professional Center 5
Surgery Care Center
Parking
B
Front Entrance
D'Antignac Street
Marks Street
Employee/ Medical Staff Parking Only
Hospital Parking Garage
A
Additional Parking
Professional Center 3
Walton Way
13th Street



820 SAINT SEBASTIAN WAY
AUGUSTA, GA 30901

PROFESSIONAL CENTER 1 - SUITE 2A

PARK IN THE PARKING DECK ON THE CORNER OF WALTON WAY & ST. SEBASTIAN (ENTRANCE ON ST. SEBASTIAN)

1ST LEVEL PARKING- ENTER BUILDING ON BOTTOM FLOOR- ELEVATOR TO 2ND FLOOR- 1ST DOOR ON LEFT

2ND/3RD LEVEL PARKING- ENTER BUILDING BY CROSSWALK IN CORNER OF PARKING GARAGE- GO DOWN LONG HALL- 1ST DOOR ON LEFT ACROSS FROM ELEVATORS

Heart & Vascular Associates of Augusta, P.C.

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Patient Financial Policy

Thank you for selecting *Heart & Vascular Associates of Augusta, P.C.* We are dedicated to providing you with the best possible care, while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy. We must emphasize that as physicians, **our relationship is with you, NOT your insurance company**. While the filing of insurance claims is a courtesy that we extend to our patients, **all charges are strictly your responsibility** from the dates services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

INSURANCES:

We participate with many insurance companies. Please check with our billing staff to see if we participate with your insurance plan.

If we DO participate with your insurance company, all services performed in our office or in the hospital will be submitted, unless we have received prior notification of non-covered services. **All co-pays and deductibles are your responsibility and are due at the time of service.**

If we DO NOT participate with your insurance company, this means that we will bill your insurance company as a courtesy. We do not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay; however, the doctor's fees may be more than what the insurance company will pay. Any balance not covered by the insurance company becomes your responsibility.

For secondary insurance, we will submit your secondary insurance claim a maximum of two times. After two submissions, the balance will be billed to you.

CO-PAYS AND OUTSTANDING BALANCES:

All co-payments are due at the time of service. If co-payments are not paid at the time of service then other arrangements must be made with the billing office. All outstanding balances on accounts are due at the time of service.

REFERRALS:

If your insurance has referral requirements, you are required to have prior authorization or a referral from your Primary Care Physician (PCP) prior to your visit. If this authorization or referral is not provided the day of service, you may be asked to either reschedule your appointment or pay at the time of service.

DISABILITY INSURANCE FORM COMPLETION:

Our office will complete your disability insurance claim forms. The fee for each form is $15.00 and must be paid in advance of or at the time you receive your completed form. If you have asked us to mail your form directly to your insurance company, you will be required to pay the $15 fee when you drop the form off at our office. **PLEASE ALLOW 5-7 BUSINESS DAYS FOR COMPLETION OF YOUR DISABILITY FORMS.**

CHECKS RETURNED FOR INSUFFICIENT FUNDS:

If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account and will also charge a $30.00 fee to your account.

COLLECTION ACCOUNTS:

Our office will make every effort to communicate with you about your account and will present reasonable options for payment. We will bill you three times. In the event a bill goes unpaid without contacting the billing department to discuss payment options, the account will be turned over to an outside collection agency.

SELF PAY POLICY:

Patients without insurance coverage must establish a payment plan with our billing department at the time of service and be prepared to make a payment at the time of service.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY *HEART & VASCULAR ASSOCIATES OF AUGUSTA, P.C.*, AND I AGREE TO THE TERMS OF THIS POLICY, AND I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THIS POLICY MAY BE AMENDED BY THE PRACTICE WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

______________________________ ______________

Signature of Patient/Guardian **Date**

FOR OFFICE USE ONLY

Do NOT write in this space

820 ST. SEBASTIAN WAY, SUITE 2A
AUGUSTA, GA 30901-2693

706.722.1249 • 706.722.1947 FAX

Effective Date: 6/1/2011

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

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 personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care;

research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you 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, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical 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. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, please write to **Privacy Officer - Debbie Saxon, 820 St. Sebastian Way, Suite 2A, Augusta, GA 30901**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.