BEATS CARDIOLOGY

7713 San Jacinto Place, #200, Plano, TX 75024.
Ph 469-409-2601. Fax 469-409-2570.

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I understand that Beats Cardiology may request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ **_____**

Signature of Patient or Personal Representative **Date:**

_____ **_____**

Printed Name of Patient or Personal Representative **Relationship to Patient**

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FINANCIAL AND OFFICE POLICIES

1. All copays, deductibles and coinsurances are due at the time of service. Co-payments are amounts that you have agreed to pay at each doctor's office visit with your insurance company. Many insurance plans also include an annual deductible amount that is your responsibility. **Please be prepared to pay both at the time of your visit.**

2. We accept cash, check, MasterCard, Visa, Discover and American Express.

3. Insurance benefits will be assigned to the physician. All insurances will be filed for the patient providing we are able to identify eligibility.

4. Statements will be mailed the first week of each month and payment is expected before the 30th of the same month for any remaining balance after your PPO or HMO plan pays its share.

5. Failure to respond to three statements requesting payment will cause us to begin collective action with either a collection agency or an attorney.

6. There is a $25 no show fee for appointments made and not cancelled within 24 hours prior to the appointment.

7. There will be a $25 fee for all returned checks and must be resolved as soon as possible. Any unresolved payments will be forwarded to the Attorney's office for collection.

8. There will NOT be any interest charge on balances that are being paid off in a timely manner.

9. If your insurance company decides to hold payment to us until they receive "additional information" from you, it is your responsibility to provide that information to your insurance company immediately. They are looking for ways to delay or deny payment for medical care.

10. Established patients may be required to fill out forms every year or as requested.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Name of Patient (print)

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[redacted] BEATS CARDIOLOGY PATIENT PRIVACY NOTICE SUMMAR[redacted]

Protecting your confidential health information is important to us. Certain federal law referred to as "**HIPAA**" protects the confidentiality of your health information (generally referred to as "**Protected Health Information**" or "**PHI**"), and we take it seriously. This summary of our **Notice of Privacy Practices** ("**Notice"** or **"Privacy Notice"**) has been prepared to provide you with a brief description of certain of the key provisions of the Notice regarding how medical and other personal information about you may be used or disclosed, and how you may obtain access to your information and its disclosure. For a more complete description of our privacy practices under HIPAA, please refer to the attached Notice.

What is Protected Health Information (PHI)?

PHI is information created or received by Beats Cardiology and transmitted or maintained in written, electronic or any other form, that relates to your past, present or future health condition, the provision of healthcare to you, and/or information about payment for the provision of your healthcare, and, which may identify you or could reasonably be used to identify you.

How may my PHI be used or disclosed?

Beats Cardiology may use or disclose your PHI to carry out your **'Treatment'** (provision, coordination or management of your healthcare or related services), **'Payment'** (obtain payment for your healthcare services, including activities that may be required by your insurer(s) to obtain approval for payment), or for other **'Health Care Operations'** (other functions that Beats Cardiology performs in connection with providing health care, i.e., quality assessments, training of medical students, credentialing, auditing and financial reporting). Use or disclosure of your PHI pursuant to the Notice may include electronic transmittal or disclosure. Beats Cardiology also sends PHI to a Health Information Exchange (HIE) to allow for information exchange for information that may be relevant to your future care i.e. in an emergency situation participating facilities and physicians can access your information for your treatment. In addition, your prior prescription information will be obtained through SureScripts to assist us in providing you treatment. You can opt out of the HIE and of SureScripts by completing the appropriate forms available when you ask your Beats Cardiology office staff.

When might Beats Cardilogy use or disclose my PHI without my authorization?

Beats Cardilogy is not required to obtain your authorization or notify you when it uses or discloses your PHI for your treatment, to obtain payment, or for other health care operations as discussed above. In addition, there are some limited exceptions where the law allows your PHI to be used to promote the Government's need to ensure a safe and healthy society. In some cases, you may be given an opportunity to agree or object before the use or disclosure of your PHI. In all cases, Beats Cardilogy will make every effort to ensure that it meets necessary prerequisites and will not use or disclose your PHI more than is permitted under the law.

What Are My Rights Under the HIPAA Privacy Standards?

Patients have certain rights under the HIPAA Privacy Standards, subject to certain limitations:

- You have the right to request restrictions on certain uses and disclosures of your PHI by Beats Cardiology.
- You have the right to request that we communicate with you in a certain way. We make every effort to honor your reasonable requests for confidential communication.
- You have the right to read, review and receive copies of your health information.
- You have the right to request and obtain an accounting of disclosures Beats Cardiology has made of your PHI.
- You have the right to request an amendment to your PHI. *(Beats Cardiology reserves the right to deny requests to amend PHI. For example, if the information is accurate, or if the information was not created or is not maintained by Beats Cardiology.)*
- You have the right to request a copy of the Privacy Notice.
- You have the right to file a complaint if you believe that Beats Cardiology has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules.

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BEATS CARDIOLOGY PRIVACY OFFICER

Beats Cardiology has procedures in place for receiving and resolving HIPAA-related complaints, and, handling other HIPAA and PHI requests and concerns. Such issues are handled by the **Beats Cardiology Privacy Officer**. You may:

- Request additional restrictions for release of your PHI
- Change restrictions/change contact information
- Request an amendment to your health record
- Request copies of the Notice
- Resolve your complaints *(complaints must be directed in writing to the Privacy Officer).*

Contact the Beats Cardiology Privacy Officer:

By Mail: Beats Cardiology, Attn: Privacy Officer, 7713 San Jacinto Pl, Suite 200 Plano, TX 75024

By Phone: (469) 409- 2601

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the **Beats Cardiology Notice Privacy Practices**

_____ _____/_____/_____

Patient Name (Print) Date of Birth

_____ _____/_____/_____

Patient Signature Date of Acknowledgement

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RELEASE OF HEALTH INFORMATION

PRIMARY CARE PHYSICIAN (PCP): _____

': _____

❑ Beats Cardiology **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone, except as permitted by HIPAA and other applicable laws.

❑ Beats Cardiology **MAY** discuss my healthcare and **MAY** discuss and/or make financial arrangements with only the following individual immediate family members listed below:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I understand that if I would like to authorize Beats Cardiology to disclose my healthcare and/or financial arrangements anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards.

_____ _____ _____/_____/_____

Patient Name (Please Print) Patient Signature Date

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection.

❑ No Expiration
❑ Date of Expiration _____/_____/_____
❑ Event: (Describe event upon which this Authorization will expire) _____

PATIENT CONTACT PREFERENCES

I prefer to be contacted in the following manner:

❑ Phone #: (_____) _____ - _____
❑ OK to leave message with detailed information
❑ OK to leave message with contact number only
❑ DO NOT LEAVE MESSAGE

All normal test results will be sent via our **Patient Portal**

Appointment reminders:

❑ Text [# if different than above (_____) _____ -_____]
❑ Phone
❑ Email

SLEEP APNEA SCREENING QUESTIONS

******Note: <u>If you have known sleep apnea</u> and are already getting treatment, you do not need to fill this out.***

Patient Engagement:

- *We assess your sleep apnea status because if you have undiagnosed and untreated sleep apnea, some of the treatments we may prescribe for your cardiac condition may not be as effective*
- *Sleep Apnea is very common in patients needing cardiovascular care (1 in 2 CV patients have sleep apnea)*
- *There are many types of treatment if the diagnostic test is positive for sleep apnea*
- *You will work with a sleep medicine team for care options if the test shows that you have sleep apnea*
- *We are committed to helping you have the best possible outcomes and this is an important step in your care*

STOP BANG RISK ASSESSMENT

	Yes	**No**
S (snore) Have you been told that you snore?		
T (tired) Are you often tired, fatigued, or sleepy during the day?		
O (obstruction) Do you stop breathing, choke, or gasp during sleep?		
P (pressure) Do you have or are you being treated for high blood pressure?		
B (BMI) Is your body mass index greater than 35 Kg/m²?		
A (age) Are you 50 years old or older?		
N (neck) Do you have a neck circumference greater than 16 inches?		
G (gender) Are you a male?		
TOTAL STOP/BANG "YES" ANSWERS		

*****Your doctor will review this with you in your appointment.**