



Heart and Vascular Care, Inc.

Clinical Cardiology • Cardiac Imaging • Diagnostic Catherization • Interventional Cardiology • Peripheral Vascular • Pacemaker Services

Aman K. Kakkar, MD, FACC
Vikram Khetpal, MD, FACC
Scott R. Beach, MD
Mehul R. Bhatt, MD, FACC

Phone: 678-513-CARE (2273)
Fax: 678-513-8869
www.hvcmd.com

CONFIDENTIAL PATIENT INFORMATION SHEET (Please Print)

Name: _____ Age: _____ D.O.B: _____ Sex: _____
 (Last) (First) (Mi)

Street Address: _____ Apt: _____ SS#: _____

City: _____ State: _____ Zip: _____ Email: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Name Nearest Relative (not living with patient): _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Employment Information

Employer's Name: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Work Tel: _____ Ext: _____

Spouses Employer: _____ City: _____ State: _____ Zip: _____

In Emergency: Name: _____ Home Phone: _____ Work Phone: _____ Ext: _____

Insurance Information

(Please present all insurance cards and picture I.D. to front desk for photocopying)

Primary Insurance Co. _____ Policy#: _____ Group#: _____

Insured's Name: _____ Insured's D.O.B: _____ Relation to Patient: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Insured's Name: _____ Insured's D.O.B: _____ Relation to Patient: _____

MEDICAL CONSENT - ASSIGNMENT OF BENEFITS - RELEASE OF INFORMATION

I hereby authorize the physicians and staff of Heart and Vascular Care Inc, to provide medical care for the above named patient.

I hereby authorize Heart and Vascular Care, Inc, to release any information in my examination or treatment to any insurance, government agency providing benefits or other policies to process any claims on my behalf for payment.

I hereby with my signature assign and authorize my insurance carrier(s) to make payment directly to Heart and Vascular Care, Inc, for all services rendered. I hereby with my signature understand I will be charged an additional fee of twenty-eight dollars (\$28.00) for any check or draft dishonored by any financial institution. ~~In the event of collection placement of my account, I understand that I will be charged a placement fee of thirty dollars (\$30.00) in addition to the balance subject to collection.~~ I understand that upon request, should the office copy my medical records and/or complete a medical necessity form, I will be charged a ten dollar (\$10.00) fee per transaction.

I hereby with my signature, understand that I am ultimately responsible for payment in full of all services rendered in the event my insurance carrier and or managed care plan denies payment in full or part of any services rendered. Including but not limited to all co-payments and or deductibles, and no covered services and supplies obtained during the course of care.

X _____ Date: _____ Patient Information Updated On: _____
 Signature of patient



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NEW PATIENT EVALUATION (PLEASE ANSWER ALL QUESTIONS)

Date: _____

Name: _____ Referring Physician: _____

Reason for Visit: _____

Past Medical History (check all that apply)

- Coronary Artery Disease High Cholesterol Thyroid Disorders Myocardial Infarction (Heart Attack) Stroke/TIA
- COPD/Lung Disease Sleep Apnea Asthma/Allergies Autoimmune Disorders Hypertension (High Blood Pressure)
- Anemia Heart Burn/Peptic Ulcers/Reflux Diabetes Mellitus Bleeding Disorders Other _____

List all Surgeries: _____

List all Allergies: _____

List all Medications: _____

Family History (check all that apply)

	Heart Disease	High Blood Pressure	Stroke	Heart Attack	Cancer	High Cholesterol	Diabetes	Seizures	Pacemaker Treatment	Congenital Defects
Father:										
Mother:										
Siblings:										

Social History/Risk Factors:

Smoker: yes no _____ packs per day Alcohol: yes no amount, if applicable _____

Caffeine: yes no amount, if applicable _____ Exercise: yes no how often: _____

Review of Systems: Please check all that apply: Acute (New Problem) Chronic (Existing Problem)

System	Problem	Acute (New Problem)	Chronic (Existing Problem)
CARDIOVASCULAR:	Chest Pain		
	Palpitations (chest fluttering)		
	Edema (swelling)		
	Paroxysmal Nocturnal Dyspnea		
	Syncope (passing out)		
RESPIRATORY:	Shortness of Breath		
	Shortness of Breath with Activity		
	Shortness of Breath Lying Flat		
	Cough		
	Wheezing		
GASTROINTESTINAL:	History of Snoring		
	Nausea		
	Vomiting		
	Heartburn/Reflux		
MUSCULOSKELETAL:	Abdominal Pain		
	Joint Pain		
	Muscle Pain		
	Muscle Weakness		
	Muscle Stiffness		
	Muscle Tenderness		



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Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) **This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your Individually Identifiable Health Information. Please review this carefully.**

- A. Our Commitment to your Privacy.** Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following information:
- How we may use and disclose your IIHI
 - Your privacy rights in your IIHI
 - Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

- B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**
HEART AND VASCULAR CARE, INC. TELEPHONE: 678-513-CARE (2273).

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses-may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our Practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

OPTIONAL:

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment for a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES. The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
 - Maintaining vital records, such as births and deaths
 - Reporting child abuse or neglect
 - Preventing or controlling disease, injury or disability
 - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - Reporting reactions to drugs or problems with products or devices
 - Notifying individuals if a product or device they may be using has been recalled.
 - Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
 - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
 - Concerning a death we believe has resulted from criminal conduct
 - Regarding criminal conduct at our offices

(continued on other side)

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victims(s) of the crime, or the description, iden

OPTIONAL:

5. **Deceased Patients.** Our practice may release IHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:

6. **Organ and Tissue Donation.** Our practice may release your IHI to organization that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:

7. **Research.** Our practice may use and disclose your IHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IHI is being used only for the research and (iii) the researcher will not remove any of your IHI from our practice; or (c) the IHI sought by the researcher only related to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access of the IHI of the decedents.
8. **Serious Threats to Health or safety.** Our practice may use and disclose your IHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military.** Our practice may disclose your IHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National Security.** Our practice may disclose your IHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates.** Our practice may disclose your IHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' Compensation.** Our practice may release your IHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IHI. You have the following rights regarding the IHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Heart and Vascular Care, Inc, 1505 Northside Blvd., Ste. 4000, Cumming, GA 30041 and specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IHI, you must make your request in writing to: Heart and Vascular Care, Inc, 1505 Northside Blvd., Ste. 4000, Cumming, GA 30041. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Heart and Vascular Care, Inc, 1505 Northside Blvd., Ste. 4000, Cumming, GA 30041, in order to inspect and/or obtain a copy of your IHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Heart and Vascular Care, Inc, 1505 Northside Blvd., Ste. 4000, Cumming, GA 30041. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IHI kept by or for the practice; (c) not part of the IHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IHI for non-treatment or operations purposes. Use of your IHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to: Heart and Vascular Care, Inc, 1505 Northside Blvd., Ste. 4000, Cumming, GA 30041. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact Heart and Vascular Care, Inc, 1505 Northside Blvd., Ste. 4000, Cumming, GA 30041.
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Heart and Vascular Care, Inc, 1505 Northside Blvd., Ste. 4000, Cumming, GA 30041. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact: Heart and Vascular Care, Inc, 1505 Northside Blvd., Ste. 4000, Cumming, GA 30041, GA 30224 or Call at 678-513-CARE (2273).

I acknowledge that I have received the Notice of Privacy Practices.

Signature

Date



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**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize Heart and Vascular Care, Inc. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

1) I give my permission to Heart and Vascular Care, Inc. to leave detailed messages on my answering machine.

Patient Signature: _____ Date: _____

2) I give my permission to Heart and Vascular Care, Inc. to discuss my medical information

with my _____ whose name is _____

Patient Signature: _____ Date: _____

3) I give my permission to Heart and Vascular Care, Inc. to discuss my financial information

with my _____ whose name is _____

Patient Signature: _____ Date: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPM Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Heart and Vascular Care, Inc. has acted in reliance upon this authorization. My written revocation must be submitted to Heart and Vascular Care, Inc's Privacy Officer at 1505 Northside Blvd., Ste. 4000, Cumming, Georgia 30041.

Signed by:

Signature of Patient or Legal Guardian: _____ Relationship to Patient: _____

Patient's Name _____ Date _____

Print Name of Patient or Legal Guardian _____



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Please provide us with the name of your pharmacy and contact information:

Date: _____

Name of Patient: _____

Date of Birth: _____

Name of Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Pharmacy Fax: _____

Please check the box if you do not currently use a pharmacy.

Thank you!