



Ricci Minella, M.D. Benjamin Kalsmith, M.D. Meghan Trojan, D.O.

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

Effective April 14, 2003

Cardiovascular Disease Specialists of Pittsburgh, PC may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers and collection agencies. Healthcare operations include, but are not limited to, Internal quality control and assurance including auditing of records.

CDSP is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. An example would be for public health requirements, court order or to report child abuse.

CDSP will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be in writing.

CDSP may at times contact the patient (or parent, if minor) to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

CDSP may use protected health information to converse or by written means with pharmacies or pharmaceutical companies that may be of interest to the individual patient.

CDSP will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

CDSP reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.

CDSP will provide each patient with a copy of any revisions of its *Notice of Privacy Practices* at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

Any person/Patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Office at the following phone number 412-924-1100. All complaints will be addressed and the results will be reported to the Corporate Compliance Officer and Managing Partners.

It is Cardiovascular Disease Specialists of Pittsburgh's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

The name, title and telephone number of the person in the office to contact for further information Jane Milbee, Privacy Officer at 412-924-1100.



Ricci Minella, M.D. Benjamin Kalsmith, M.D. Meghan Trojan, D.O.

**5750 Centre Ave. Suite 510
Pittsburgh, PA 15206
Phone: 412-924-1100**

**575 Coal Valley Rd. Suite 210
Clairton, PA 15025
Phone: 412-469-7788**

COMMUNICATION CONSENT

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. The Administrative Simplification section of this Act is of concern to our practice and requires us to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare Transactions & Code Sets for transmitting electronic data
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services and will become final in a staged manner.

It will be the policy of CDSP to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, e-mail, cellular phone, pager and/or fax. Whenever returning telephone calls and an answering machine picks up, we will not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer your telephone.

If you would like to have your medical information released to someone other than yourself, please complete the following:

I authorize Cardiovascular Disease Specialists of Pittsburgh, PC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Cardiovascular Disease Specialists of Pittsburgh, PC can contact me anywhere reasonably necessary for medical care.

Home Telephone _____	Yes	No
Answering Machine _____	Yes	No
Work Telephone _____	Yes	No
Voice Mail _____	Yes	No
Cellular Phone _____	Yes	No
Pager _____	Yes	No

Please provide name of authorized person(s):

Spouse/Fiancé _____	Yes	No
Parent _____	Yes	No
Brother/Sister _____	Yes	No
Son/Daughter _____	Yes	No
Friend/Roommate _____	Yes	No

Patient/Guardian Signature _____ Date _____

Patient's Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Alternate Number: _____

Social Security Number: _____ Date of Birth: _____

Emergency Contact: _____

Relationship to you: _____ Phone: _____

Reason for visit: _____

Referred By: _____

Primary Care Physician: _____

I request that payment of authorized Medicare/Medigap Benefits (If applicable) be made payable to Cardiovascular Disease Specialists of Pittsburgh, PC (Ricci Minella, M.D./Benjamin Kalsmith, M.D./Brian Carey, M.D./Meghan Trojan, D.O.) for any services furnished me by those physicians. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services

I understand that Cardiovascular Disease Specialists of Pittsburgh, P.C. will be submitting a claim to my insurance carrier for payment of services rendered to me by Ricci Minella, M.D., Benjamin Kalsmith, M.D., Brian Carey, M.D., Meghan Trojan, D.O.

In the event that I should receive the check from my insurance carrier, I agree to remit the check directly to Cardiovascular Specialists of Pittsburgh, P.C. I also agree to pay any balance that may be remaining (i.e., deductibles, co-insurance, maximums, percentages not paid, etc.)

Signed: _____ Date: _____

MEDICAL HISTORY

Reason for visit: _____

Do you have a history of heart disease? NO YES (Please explain)

Have you ever had a cardiac catheterization? NO YES

If yes, where and when? _____

Have you ever had coronary artery bypass grafting? NO YES

If yes, where and when? _____

Do you have a history of hypertension? NO YES

Do you have a history of diabetes? NO YES

Do you smoke? NO YES How much? _____

If former smoker, date quit? _____

Please list any prior surgeries (type/place/date):

WOMEN: Could you be pregnant? NO YES

Please check any of the following that apply:

Cardiovascular:

- Chest, neck, jaw, or back discomfort with exertion
- Shortness of breath
- Shortness of breath that awakens you at night
- Need to have head of bed elevated or additional pillows when you sleep
- Leg or ankle swelling
- Fluttering sensation in your chest or palpitations
- Lightheadedness or dizziness
- Passing out
- Cramping, pain, or discomfort or weakness in legs or buttocks with activity
- Fatigue

Respiratory:

- Cough
- Coughing up blood
- Shortness of breath
- Wheezing

Gastrointestinal:

- Nausea
- Vomiting
- Abdominal Pain
- Constipation
- Blood in stool
- Heartburn, reflux
- Tarry or black stool

Geno-urinary:

- Burning or pain with urination
- Frequency with urination
- Blood tinged urine
- Foul smelling urine
- Inability to control bladder function
- Flank pain

Musculoskeletal:

- Joint pain
- Muscle pain
- Stiffness in joints/limbs
- Swelling of joints/limbs
- Gout
- Redness of joints/limbs

Vascular:

- Phlebitis
- Varicose Veins

Neurological:

- Seizures
- Frequent Headaches
- Changes in vision
- Changes in taste
- Problems with equilibrium or balance
- Paralysis or weakness (where): _____
- Numbness, tingling or tremors (where): _____

Endocrine:

- Extreme thirst
- Hair Loss
- Weight gain
- Flushing
- Change in appetite
- Excessive hair growth
- Weight loss
- Heat or cold intolerance

Skin:

- Rashes or sores
- Masses
- Dryness/itchy skin
- Yellow discoloration of skin

OB/GYN:

- Post-menopausal
- Hysterectomy
- Pregnancies (number) _____
- Miscarriages (number) _____
- Post-menopausal bleeding

Hematology:

- Easy bruising
- Chills
- Night sweats
- Bleeding
- Fever
- Lymph node enlargement

Physician Signature: _____

Date: _____

New Patient Questionnaire

Name: _____

Date: _____

Medications:

Please list your medications, including over the counter supplements.

MEDICATION	DOSE (MG)	FREQUENCY (EX: ONCE DAILY, TWICE DAILY, ETC.)

Pharmacy Name: _____ Pharmacy Phone No.: _____

Are you allergic to any medications? NO YES

If yes, please list the medication(s) and type of reaction below:

I understand that the office may need to discuss results with me over the telephone. I can be reached best at:

Home () _____ Hours: _____
Work () _____ Hours: _____
Cell: () _____



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CONSENT TO THE USE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR
HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Cardiovascular Disease Specialists of Pittsburgh, PC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that CDSP reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided, upon written request to do so. I understand that I have the right to see and obtain copies of my medical record upon written request and during normal business hours and a designated time set by CDSP. I understand that I have the right to request amendments be made to my medical record. All amendments need to be written on a separate sheet of paper and duly indicated "Amendment To The Record". I understand that a six-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history within 60 days of my written request and I understand that I may have to pay a reasonable charge for any copies. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is required to agree to the restrictions requested. If CDSP does agree to any restrictions, the agreement is binding on use. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and healthcare operation purposes.

Patient's Name (please print) _____

Signature of Patient or Legal Representative _____ Date _____



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NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Cardiovascular Disease Specialists of Pittsburgh, PC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting our organization at 412-924-1100

If you have any questions about our *Notice of Privacy Practices*, please contact:

Jane Milbee, Practice Manager

I acknowledge receipt of the *Notice of Privacy Practices of Cardiovascular Disease Specialists of Pittsburgh, PC*

Signature: _____ Date: _____
(Patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Provider Representative: _____
Date: _____