CARDIOVASCULAR DISEASE SPECIALISTS OF PITTSBURGH, PC

Ricci Minella, M.D. Benjamin Kalsmith, M.D. Meghan Trojan, D.O. Joseph O'Toole, M.D.

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 January 31, 2020

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, Jane Milbee, 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 is Jane Milbee, Privacy Officer at 412-924-1100.

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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.

I hereby give permission to Cardiovascular Disease Specialists of Pittsburgh, PC to discuss my medical information with the following people:

NAME	RELATIONSHIP	PHONE NUMBER

Patient/Guardian Signature_____ Date_____

Patient's Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Number: _____

Social Security Number: _____ Date Of Birth: _____

Emergency Contact: _____

Relationship to you: _____ Phone: _____

Reason seen today: _____

Referred by: _____

Primary Care Physician: _____

I request that payment of authorized Medicare Benefits be made payable to Cardiovascular Disease Specialists of Pittsburgh, PC (Ricci A. Minella, M.D./ Benjamin M. Kalsmith, M.D./Meghan K. Trojan, D.O., Joseph O'Toole, M.D.) for any services furnished to 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 request that payment of authorized Medigap benefits to be made either to me or on my behalf to Cardiovascular Disease Specialists of Pittsburgh, PC (Ricci A. Minella, M.D./ Benjamin M. Kalsmith, M.D./ Meghan K. Trojan, D.O., Joseph O'Toole, M.D.) for any services furnished me by those physicians. 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.

Signed: _____ Date: _____

I understand that Cardiovascular Disease Specialists of Pittsburgh, PC will be submitting a claim to my insurance carrier for payment of services rendered to me by Ricci A. Minella, M.D., Benjamin M. Kalsmith, M.D., Meghan K. Trojan, D.O., Joseph O'Toole, M.D.

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

Signed: _____ Date: _____

Patient's Name: _____

I authorize the release of my medical records including _____

To: Cardiovascular Disease Specialists of Pittsburgh, PC (Ricci A. Minella, M.D., Benjamin M. Kalsmith, M.D., Meghan K. Trojan, D.O., Joseph O'Toole, M.D.)

Signed: _____ Date: _____

Do any of these apply to you?

Ablation	___	Aortic Aneurysm	___
Bypass Surgery	___	Cardiac Stents	___
Carotid Disease	___	Chest Pain	___
Defibrillator	___	Diabetes	___
Heart Attack	___	Heart Failure	___
Heart Murmur	___	High Cholesterol	___
Hypertension	___	Pacemaker	___
Palpitations	___	Pulmonary Embolism	___
Rheumatic/Scarlet Fever	___	Stroke or TIA	___
Current Smoker	___	Former Smoker	___
		Quit _____	

Do any of these apply to your immediate family?

Please circle **M**=Mother, **F**=Father, **S**=Sister, **B**=Brother

Aortic Aneurysm	M F S B	Bypass Surgery	M F S B
Cardiac Stents	M F S B	Diabetes	M F S B
Heart Attack	M F S B	Heart Failure	M F S B
High Cholesterol	M F S B	Hypertension	M F S B
Stroke or TIA	M F S B	Sudden Cardiac Death	M F S B

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.

_____

_____

_____

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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: _____