CLAIMS AUTHORIZATION FOR MEDICARE, BLUE SHIELD, AND OTHER COMMERCIAL CARRIERS

MEDICARE:

I request that payment of authorized Medicare benefits be made on my behalf to this office for any services furnished to me by Robert Feinstein, M.D. and/or Feinstein Cardiovascular Disease Specialists, P.A. I authorize any holder of medical information about me to release to the Health Care Financing Administration and the Social Security Administration and its agents and any information needed to determine these ben efits payable for related services. I permit a copy of this authorization to be used in place of the original.

COMMERCIAL INSURANCE AND BLUE CROSS INSURANCE:

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to my insurance company.

I also authorize my insurance company to disclose to a hospital or health care service plan, self -insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or terms of coverage with my insurance company including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon my dependents, and our heirs, executors, administrators, and myself.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for any balan ce not covered by my insurance carrier.

I recognize that I am responsible for obtaining necessary insurance preauthorizations/precertifications if required by my insurance entity and that I will be directly liable for payment of services rendered by Robert Feinstein, M.D. and/or Feinstein Cardiovascular Disease Specialists, P.A., his associates, and future business entities if such a preauthorization/precertification is not obtained.

Additionally, I may be billed directly for services and will be responsibl e for submitting superbills to my insurance company, if my insurance company mails checks to patients directly and not physicians.

I have read and understand the above document.

I acknowledge that my electronic or scanned signature will be used in lieu of a handwritten/pen signature and will be considered valid for all legal purposes.

Signature of Patient or Guardian: _____

Date: _____

FEINSTEIN CARDIOVASCULAR DISEASE SPECIALISTS, P.A.

PAYMENT TERMS:

I hereby request and authorize my insurance company and/or companies to pay assignments pertinent to me directly to Robert Feinstein, M.D. and/or Feinstein Cardiovascular Disease Specialists, P.A. or any proceeds payable under the terms of my policy and/or policies. This is an irrevocable assignment and I understand and agree that any unpaid balance not covered by my policy and/or policies is my obligation and will be paid by me, inclusive of any costs of collection or service charge for terms, if any.

MEDICAL INFORMATION RELEASE:

I hereby give consent to Robert Feinstein, M.D. and/or Feinstein Cardiovascular Disease Specialists, P.A. to release any and all medical information and records pertaining to my claim to my insurance company and/or companies or to my attorney.

MEDICAL INFORMATION RELEASE:

I hereby request my other physicians and medical facilities to release pertinent medical records, including test results, consultations, and office records to Robert Feinstein, M.D. and/or Feinstein Cardiovascular Disease Specialists, P.A. so that they may have a complete picture of my medical condition.

Date: _____

Signature: _____

Patient's Name Printed: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003

By giving your consent, the provider is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected Health Information (PHI) is any information we create and obtain in providing our services to you that can be identified as your information. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- An employee of the provider's office obtains treatment information about you and records it in a health record.
- During the course of your treatment, the provider determines that he/she will need to consult with another specialist in the area. He/She will share the information with such specialists and obtain his/her input.

An example of use of your health information for payment purposes:

- We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding services rendered. We will provide that information to them about you and the care you receive.
- We may verify insurance coverage and obtain prior authorization and precertification when required to do so by your policy coverage.

An example of use of your health information for health care operations:

- The state licensing authority wants to review records to assure that we have acted consistent with state law regarding your care. In doing so, it wants to take a sampling, which includes review of your chart. At the licensing authority's request, we will provide it with a copy of your chart.

Your health information rights:

The health record and billing records we maintain are the physical property of the provider of services. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to the provider. We are not required to grant the request, but we will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to the provider using the form we provide to you upon request.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to the provider using the form we provide to you upon request.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to the provider using the form we provide to you upon request. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to the office using the form we provide to you upon request.
- Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to the provider.

You have the right to review this notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please contact: **Feinstein Cardiovascular staff** in person, or in writing, during normal business hours. He/She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The provider is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain abo ut you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information to you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice to reflect these changes. You are entitled to receive a revised copy of the Notice by calling or requesting a copy of our Notice or by visiting the office to obtain a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to r eport a problem regarding the handling of your information, you may contact: _____

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to: _____

You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Uses and Disclosures

- We have business associates with whom we may share your protected health information.
- For example, in preparing our annual financial statement, auditors may need to review samples of medical care given. We may disclose your health information to the accounting firm to prepare this materia1.
- For example, during our routine health care operations, we m ay need to hire computer technicians and software vendors. We may disclose your health information to these vendors to maintain daily functioning in our health care operations.

Notification

Unless you object, we may use or disclose your protected healt h information to notify, or assist in notifying, a family member, personal representative, or other persons responsible for your care, about your location, about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

We may use and disclose your protected health information to assist in disaster relief efforts.

Workers' Compensation

If you are seeking compensation through Workers' Compensation, we may disclose your protected health information to the exten t necessary to comply with laws relating to Workers' Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institu tion or agents there of your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

To avert a serious threat of health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses
Other uses and disclosures in addition to those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke that authorization as previously stated.

Web Site
We may maintain a Web Site that provides information about our business. This Notice is on the Web Site.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

I acknowledge that my electronic or scanned signature will be used in lieu of a handwritten/pen signature and will be considered valid for all legal purposes.

Signature: _____ **Date**: _____

Signature of Personal Representative of Patient : _____

Description of Representative's Authority to Act on behalf of Patient: _____