CARDIOVASCULAR CONSULTANTS OF MONTANA

1101 North 27th Street Suite F Billings, Montana 59101 406.325.5555 phone 406.325.5556 fax

JOSEPH C APOSTOL, MD, FACC
R. BRANDON HENCKEL, MD
MARY TUCKER, PA-C
CHRISTINA YF HO, MD
Managing Partner

Health Insurance Portability and Accountability Act (HIPAA)

CardioVascular Consultants of Montana is entrusted by its patients and is required by law to ensure the security of individually identifiable health information. This protected health information is preserved by law and regulatory requirements and upheld by each individual with this organization.

- We are subject to the compliance of the law as we are a health care provider and we maintain and transmit health information in electronic form in connection with transactions referred to as claims, encounters, eligibility, referrals, payments, electronic remittance, coordination of benefits, claim status, first report of injury, health claim attachments and any other transactions as the Secretary may prescribe by regulation

- We are permitted to use and disclose protected health information for the purpose of treatment, payment, and health care operations

- We shall make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure. When making disclosures to public officials we will reasonably rely on the representations of such officials that the information requested is the minimum necessary for the stated purpose(s)

- We may use or disclose any de-identified protected health care information provided that the key or other devices designed to enable coded or otherwise de-identified information is not used or provided

- We recognize all individually identifiable health information identifiers as created, received and used within our electronic computer systems and will make every reasonable effort to ensure they are secure in our environment. These identifiers are listed as: Name, address (street, city, county, zip code), names of relatives, names of employers, birth date, telephone numbers, fax numbers, social security number, medical record number, account number, health plan beneficiary number, certificate or license number, E-mail address, IP address, vehicle or other device serial number, Web URL, finger or voice prints, photographic images, and any others added by the Secretary in future regulations

- The death of a patient does not terminate his rights to protection of health information. We shall apply all reasonable efforts to protect the individually identifiable health information of a deceased individual in the same manner we protect the living. This policy shall be in effect for two years following the death of the individual

- I give my physician permission to communicate health information via my answering machine or voicemail

_____ _____

Signature Date

_____ _____

Print Name Relationship to Patient (if not patient)

REV 10/17

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Authorization for CardioVascular Consultants of Montana Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

Address:_____

SSN: _____Telephone Number _____

I request and authorize _____to release health care information of the above named patient to:

☐ **CardioVascular Consultants of Montana**
1101 North 27th Street Suite F
Billings, MT 59101-0101

☐ _____
_____
_____

Purpose for release of information: ☐ Continuing patient care ☐ Personal

Responses to requests will contain a records abstract of three (3) most recent years from the last date of service. This will include:

- For clinic records – Provider Notes, Operative/Procedure Reports, and Test/Lab Results
- For hospital records – History and Physical, Discharge Summary, Operative/Procedure Reports, Emergency Department Reports, Consultation Reports, and Test/Lab Results

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral and/or mental health care, alcohol and/or drug abuse treatment, medication history, and genetic testing, if any such records exist.

I understand that CardioVascular Consultants of Montana will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that CardioVascular Consultants of Montana has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: CardioVascular Consultants of Montana, 1101 North 27th Street Suite F, Billings, MT 59101-0101. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that receives the information.

I understand that this authorization will expire one (1) year from the date of signing.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient (if not patient)

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Family Release of Information

Patient Name:_____ **Date of Birth:**_____

Social Security #_____

CardioVascular Consultants of Montana is authorized to release protected health information pertaining to the patient named above to the entities and/or individuals below.

Entity/Individuals to Receive Information *(Check all that apply)*

_____Give information to Spouse _____

_____Give information to the following persons:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

_____ OK to leave information on voice mail

Description of Information to be Released *(Check all that apply)*

_____Medical Information: _____All or Specific_____

_____Financial information (ie. account balances, billing statements, insurance)

_____I DO NOT authorize the release of any information at this time

Patient Rights

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed as described in this document by sending a written notification to CardioVascular Consultants of Montana. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used to disclose as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal and State law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked in writing by the patient or representative signing the authorization.

_____ _____

Patient signature or Personal Representative Date

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Financial Responsibility Statement

CardioVascular Consultants of Montana requires payment for all medical services and testing on date of visit.

Copayment (co pays) will be collected at time of check-in.

For patients who have health insurance, CardioVascular Consultants of Montana will submit all charges to your medical insurance carrier. Patient will be responsible for any charges that their insurance company does not pay which includes, but is not limited to: any additional co pays, coinsurance, deductibles, and non-covered services.

I hereby authorize all insurance benefits to be paid directly to CardioVascular Consultants of Montana. I further authorize the release of any medical information necessary to process all insurance claims.

CardioVascular Consultants of Montana recognizes that every patient may not be able to meet our payment requirements and is concerned when patients have difficulty paying their medical bills. Payment options are available to assist patients with their financial responsibilities and medical obligations. Unpaid account balances over 90 days from date of service, excluding accounts on pre-arranged payment plans, will be turned over to a collection agency and patients may be subject to dismissal from the practice.

To learn more about our payment programs and make payment arrangements, please speak to our Director of Financial Relations prior to your appointment.

I have read and understand this payment policy. I accept responsibility for payment in full of all my medical services.

_____ _____

Signature Date

_____ _____

Print Name Relationship to Patient (if not patient

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