
THE INFORMATION YOU PROVIDE ALLOWS US TO GIVE YOU THE BEST TREATMENT OPTIONS

**PATIENT INFORMATION**

**NAME:** _____ **DOB:** _____

**SSN:** _____ **MARITAL STATUS: M S W D**

**ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

**PHONE #:** _____ **ALTERNATE PHONE#:** _____

**EMAIL:** _____

**EMERGENCY CONTACT:** _____ **PHONE #:** _____

**HEIGHT:** _____ **WEIGHT:** _____

**PRIMARY CARE PHYSICIAN:** _____ **PHONE #:** _____

**REASON FOR YOUR VISIT TODAY?** _____

**ALLERGIES TO ANY MEDICATIONS? YES NO IF YES, PLEASE LIST:**

_____

**ARE YOU CURRENTLY A DIALYSIS PATIENT? YES NO IF YES, PLEASE PROVIDE CLINIC NAME AND YOUR DIALYSIS DAYS**_____

**WHO REFERRED YOU TO US TODAY?** _____

**PREFERRED PHARMACY & LOCATION:** _____

PLEASE LIST ANY SURGICAL PROCEDURES AND DATES: _____

_____

OTHER PERTINENT MEDICAL HISTORY THAT WE SHOULD BE AWARE OF? _____

_____

DO YOU SMOKE? YES NO QUANTITY_____

DO YOU DRINK? YES NO QUANTITY_____

AIKEN VASCULAR SPECIALISTS

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS? PLEASE PUT YES BY THE ONES THAT APPLY TO YOU.

| | | |
|---|---|---|
| HIGH BLOOD PRESSURE | COPD | BELLS PALSY |
| CONGESTIVE HEART FAILURE | ASTHMA | HIV |
| HEART ATTACK | EMPHYSEMA | HEPATITIS B |
| CANCER | KIDNEY DISEASE | HEPATITIS C |
| DIABETES | THYROID ISSUES | C-DIFF |
| STROKE | HIGH CHOLESTEROL | MRSA |
| BLOOD CLOTS | CIRRHOSIS | CURRENT ON COVID VACCINE |
| PHLEBITIS | VARICOSE VEINS | |

PLEASE LIST ALL CURRENT OVER THE COUNTER AND PRESCRIBED MEDICATIONS THAT YOU ARE TAKEN

| MEDICATION NAME | DOSE OF MEDICATION | HOW OFTEN? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**INSURANCE**

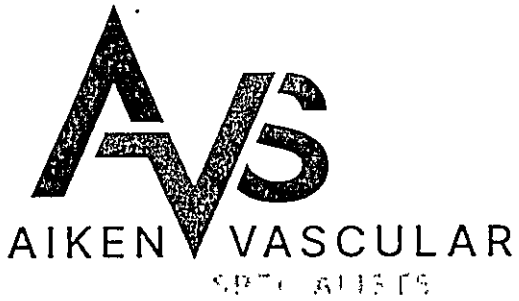
INSURANCE COMPANY: _____ POLICY GROUP#: _____

IF POLICY HOLDER NAME IS DIFFERENT, PLEASE ADD: _____

I UNDERSTAND THE ABOVE INFORMATION IS REQUIRED TO PROVIDE ME WITH THE PROPER MEDICAL CARE IN A SAFE AND EFFICIENT FASHION. I HAVE COMPLETED THE ABOVE TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, I GIVE MY CONSENT TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY TO RELEASE MY INFORMATION. I WILL NOTIFY THE DOCTOR OF ANY CHANGES IN MY HEALTH, MEDICATION, OR INSURANCE COVERAGE.

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____




**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.**

If you have any questions about this notice, please contact our office at (803) 602-4343.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your Protected Health Information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care services. Your Protected Health Information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your Protected Health Information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. We have not listed every use or disclosure, but only give some examples for understanding.

**Certain Situations Do Not Require Your Authorization**

- To prevent or control disease, injury, or disability.
- To report births and deaths.
- To report abuse or neglect.
- To report reactions to medications, problems with products or other adverse events.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To avert a serious threat to you or others. These disclosures would be made only to have someone able to intervene.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
- Immunization records to a school requiring such for entry, provided informal approval is given by a parent, guardian, or the patient if the patient is an adult or emancipated minor.
- To disaster Relief agencies for notification as to your location and condition.
- If you are an organ donor, we may release health information to the organizations that handle the process, as necessary to facilitate the donation.

**Law Enforcement:** We may disclose health information to law enforcement officials for reasons such as:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct at our facility.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Military and Veterans:** If you are a member of the armed forces, we may release health information about you as required by military command authorities.

**Worker's Compensation:** We may release health information about you for worker's compensation or similar programs if you have a work-related injury.

**Health Oversight Activities:** Aiken Vascular Specialists may disclose health information to a health oversight agency for activities authorized by law. These include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliances with the civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, we may be required to disclose your health information in response to a court order, administrative order, subpoena, discovery request or other lawful proves by someone involved in the dispute.

**National Security and Intelligence Activities:** We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**Inmates:** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information about you to the institution or official. This is necessary for the correctional institution to provide you with health care, and to protect the health and safety of you, others, and the correctional institution.

**Legal Requirements:** We will disclose health information about you without your permission when required to do so by federal, state, or local law.

**Health Records of Deceased Patients:** We may disclose health information to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral home directors as necessary to carry out their duties. We may disclose to relatives or close personal friends who were involved with the patient's care prior to death, health information relevant to their involvement. HIPAA privacy protections continue until 50 years after the patient's death.

**Common Uses and Disclosures Allowed by Law**

**Treatment:** We may use your health information to provide you treatment and services. We may disclose health information about you to others who are involved in your care.

**Payment:** We may use and disclose your health information so the treatment and services you receive at Aiken Vascular Specialists may be billed to and payment collected from you, an insurance company or a third party. We may also disclose health information to your insurance plan to obtain prior authorization for treatment and procedures.

**Health Care Operations:** We may use and disclose your health information for health care activities such as quality assurance, administration, Aiken Vascular Specialists financial and business planning and development, and customer service (including investigation of complaints). These uses and disclosures are necessary to operate our health care facility and make sure patients receive quality care.

**Contacting You About Your Health:** We may use and disclose health information to contact you, such as reminders for your appointments or other treatment options at Aiken Vascular Specialists.

**Individuals Involved in Your Care:** We may disclose health information about you to a friend or family member who is involved in your care, unless you tell us in advance not to do so.

**Other Laws:** At times there are federal, state, or local laws that require us to use or disclose health information in other ways or give you additional privacy protections. We will obey those laws.

## Other Uses and Disclosures Require Your Authorization

Other uses and disclosures of health information not covered by this notice or applicable laws will be made only with your written permission (called "authorization"). If you do give authorization in some instance, you may revoke that authorization in writing at any time

Your authorization is also required before we can use or disclose psychotherapy notes about you for any purpose other than basic treatment and healthcare operations.

## Your Health Information Rights

You have the following rights concerning your health information:

- Request a restriction on certain uses and disclosures of your information. We may agree to your request but are not required by law to do so, with the one following exception...
- Restricting disclosures to health plan or insurance for treatment you pay for in full. If you pay in full at the time of service and request, we not disclose the information to your health plan or insurer, we must and will comply.
- Obtain a copy of this Notice of Privacy Practices upon request.

- Inspect and/or request a copy of your health record. You must make the request in writing, and we have 30 days to comply.
- Request an amendment to your health record if you feel the information is incorrect or incomplete. Aiken Vascular Specialists may deny your request if, for instance, we believe it is accurate and complete as it stands.
- Obtain an accounting of disclosures of your health information. This will include the times when someone used or disclosed your health information other than the allowed common uses and disclosures or uses and disclosures that you authorized.
- Request communication of your health information by alternative means or locations. For instance: an address or phone number other than your home.
- Revoke a previously agreed upon authorization except to the extent that action has already been taken.

**We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.**

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services at www.hhs.gov or in writing to Attn: Privacy Officer DHEC compliance Office 2660 Bull Street, Columbia, SC 29201. The telephone number is (803) 898 3718. There will be no retaliation for filing a complaint.

We may make your medical information available electronically through state, regional, or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants.

BY SIGNING THIS DOCUMENT, YOU ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

NAME OF PATIENT:_____

SIGNATURE OF PATIENT:_____DATE:_____