MEDICAL HISTORY

W. Edward Hanks, M.D.

Name: _____ **DOB:** _____ **/ Age:** _____**Date:** _____

Your referring physician: _____**Your regular doctor:** _____

I. Cardiovascular History

What are your present CARDIAC problems?

_____ Chest discomfort
_____ Palpitations
_____ Dizziness, Lightheadedness, Passing Out
_____ Shortness of breath

_____

_____

Have you ever had:

_____ Angina (Cardiac chest discomfort)
_____ Heart attack
_____ Heart murmur
_____ Heart surgery
_____ Aortic aneurysm (Ballooning of a blood vessel)
_____ Loss of consciousness
_____ Blood clots (If so, where? _____)
_____ Rheumatic heart disease
_____ Pericarditis (Inflammation / fluid in the heart sack)
_____ Palpitations or Heart rhythm disorder
_____ Emphysema
_____ Other heart disease: _____

Have you ever had any of the following diagnostic procedures performed?

_____ Exercise stress testing Date: _____
_____ Coronary arteriography (angiogram, heart catheterization) Date: _____
_____ Holter monitor (24-hour heart monitor) Date: _____
_____ Echocardiography (Heart sound wave test) Date: _____

II. Coronary Risk Factors

Smoking

Current Cigarette Smoking Status:
_____ Never smoked
_____ Current Smoker
How much do you smoke? _____
How many years have you been smoking? _____
_____ Ex-smoker
How much did you smoke? _____
How many years did you smoke? _____ / When did you stop? _____

Caffeine

_____ Coffee _____ Cups per day.
_____ Tea _____ Cups per day.
_____ Soft drinks _____ Cans or bottles per day.
_____ Chocolate _____ How much per day.

High Blood Pressure

Have you ever been told you have high blood pressure? _____
If so, how long ago? _____
Have you ever taken medication for high blood pressure? _____
Name(s) of medication: _____
Do you take such medications now? _____

Cholesterol (Blood Fat)

Have you ever been told that your cholesterol was too high? _____
If so, how long ago? _____
Do you know the results? _____ / on Medication? _____ mg

Sugar Diabetes

Have you ever been told that you have diabetes or "high blood sugar?" _____
If so, how long ago? _____
Do you take insulin? _____
Do you take pills for your diabetes? _____ / on Medication? _____ mg

Genetic History

Do you have an identical twin? _____
Have your parents, brothers or sisters had the following:
Cardiac chest pain before age 60? _____
Heart attack before age 60? _____
Died suddenly before age 60? _____
High cholesterol? _____

III. Past Medical History

Past hospitalization, serious illnesses or operations:

_____
_____
_____

Have you ever had the following?
_____ Lung disease _____ Kidney disease _____ Stomach, gallbladder, bleeding ulcers
_____ Cancer (type _____) Other diseases _____
_____

Current Medications and Dosages

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to Medications: _____
Any other allergies: _____

Are you presently taking any of the following medications? Put a check (✓)

_____ Aspirin, Bufferin, Anacin
_____ Cortisone
_____ Digitalis
_____ Hormones
_____ Thyroid Medicine
_____ Tranquilizers
_____ Coumadin (Blood Thinner)
_____ Water Pills
_____ Antibiotics
_____ Birth Control Pills
_____ Pronestyl
_____ Quinidine / Quinaglute
_____ Sleeping Pills

IV. Family History

	Alive and Well at Age	Illnesses	Deceased at Age	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

V. Social History

Married ____ Divorced ____ Single ____ Widow _____ Number of children: _____
Are you retired? _____ For how long: _____ What was your occupation: _____
Are you currently working? _____ What is you occupation: _____
How many hours do you work per week? _____
Are the majority of your hours spent Sitting? _____ / Walking? _____ / Standing? _____

On average how much time do you spend weekly in activities vigorous enough to cause sweating:
___None ___1-3 hours ___Greater than 3 hrs/wk
What kind of recreational activities do you do? _____
_____
How many hours do you sleep per night on average? _____
How often do you drink alcohol? Occasionally _____ Daily _____ Nondrinker _____
Living circumstance: Alone _____ / Spouse _____ / Relative _____
_____ Apartment / _____ House / _____ Nursing Facility

REVIEW OF SYSTEMS

NAME:_____ DATE:_____

	NOW	PAST
GENERAL		
1. Weight loss/gain: amount	_____	_____
2. Fevers/chills	_____	_____
3. Tired all of the time	_____	_____
4. Other: _____	_____	_____
EYES		
5. Worsening vision	_____	_____
6. Eye pain	_____	_____
7. Eye discharge	_____	_____
8. Double vision	_____	_____
9. Other:_____	_____	_____
EARS,NOSE,MOUTH,THROAT		
10. Nosebleeds	_____	_____
11. Ringing in ears	_____	_____
12. Other:_____	_____	_____
CARDIOVASCULAR		
13. Chest pains or pressure	_____	_____
14. Racing heart	_____	_____
15. Irregular heart beats	_____	_____
16. Wake up short of breath	_____	_____
17. Other:_____		
RESPIRATORY		
18. Short of breath at rest	_____	_____
19. Short of breath on exertion	_____	_____
20. Cough	_____	_____
21. Phlegm	_____	_____
22. Other:_____	_____	_____
GASTROINTESTINAL		
23. Heartburn	_____	_____
24. Nausea	_____	_____
25. Vomiting	_____	_____
26. Blood in stools	_____	_____
27. Other:_____	_____	_____
GENITOURINARY		
28. Frequent urination	_____	_____
29. Hard to urinate	_____	_____
30. Blood in urine	_____	_____
31. Sexual dysfunction	_____	_____

	NOW	PAST
MUSCULOSKELETAL		
32. Joint swelling or pain	_____	_____
33. Leg swelling	_____	_____
34. Leg pain	_____	_____
35. Other:_____	_____	_____
SKIN/BREAST		
36. Rash	_____	_____
37. Sores or wounds	_____	_____
38. Other:_____	_____	_____
NEUROLOGIC		
39. Convulsions/seizures	_____	_____
40. Loss of memory	_____	_____
41. Dizziness	_____	_____
42. Headaches	_____	_____
43. Paralysis	_____	_____
44. Other:_____	_____	_____
PSYCHIATRIC		
45. Depressed feelings	_____	_____
46. Anxious or panic feelings	_____	_____
47. Other:_____	_____	_____
ENDOCRINE		
48. Swelling in neck	_____	_____
49. Thirsty often	_____	_____
50. Other:_____	_____	_____
HEMATOLOGIC/LYMPH		
51. Blood clotting problems	_____	_____
52. Vein stripping	_____	_____
53. Easy bruising/bleeding	_____	_____
54. Other:_____	_____	_____

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PATIENT INFORMATION SHEET

NAME:				SS #
ADDRESS:				HOME:
CITY:		STATE:	ZIP:	CELL:
DOB:	FEMALE / MALE	MARRIED: Y / N	SPOUSE:	WORK:
IF A CHILD, PARENT'S NAME:			THE BEST TIME TO REACH ME IS AT:	
RACE:		**ETHNICITY**:		**LANGUAGE**:

I PREFER TO BE CONTACTED BY: ☐ HOME PHONE ☐ CELL PHONE ☐ MAIL ☐ **PATIENT PORTAL (SECURE E-MAIL)**

E-MAIL ADDRESS FOR PATIENT PORTAL: (PRINT CLEARLY)

WHO REFFERED YOU TO OUR OFFICE?

NAME OF FAMILY PHYSICIAN:

EMPLOYER (OR PARENT'S IF A MINOR)	COMPANY	OCCUPATION	HOW LONG?
	ADDRESS:		PHONE:
SPOUSE'S EMPLOYER	COMPANY	OCCUPATION	HOW LONG?
	ADDRESS:		PHONE:

SPOUSE SS#:	SPOUSE DOB:
EMERGENCY CONTACT:	RELATIONSHIP
ADDRESS:	PHONE:

☐ **PRIMARY INSURANCE**	INSURANCE NAME:	
	INSURED / SUBSCRIBER'S NAME:	
	ID#:	GROUP / PLAN / POLICY #:
☐ **SECONDARY INSURANCE**	INSURANCE NAME:	
	INSURED / SUBSCRIBER'S NAME:	
	ID#:	GROUP / PLAN / POLICY #:
☐ **WORKERS' COMP INFO**	COMPANY NAME:	
	SUPERVISOR NAME:	
	COMPANY PHONE:	SUPERVISOR PHONE:

I hereby authorize my insurance benefits to be paid directly to Cardiovascular Consultants of Fresno. I understand that I am financially responsible for all services not covered by my insurance company, which includes my annual deductible.

***If you are an HMO patient, also read and initial this statement:** I am aware that if Cardiovascular Consultants does not receive a referral from my primary care doctor all charges will be my responsibility. *_____ **(Initials)**

DATE	**PATIENT OR PARENT SIGNATURE**

OFFICE USE ONLY	**ACCOUNT NUMBER**	**REGISTRAR**

CARDIOVASCULAR CONSULTANTS HEART CENTER

KEVIN J. BORAN, MD, FACC, FSCAI / W. EDWARD HANKS, MD, FSCAI / DONALD W. GREGORY, MD, FACC / ROHIT SUNDRANI, MD, FACC, FSCAI
MICHAEL W. GEN, MD, FACC, FSCAI / CHANDRASEKAR PALANISWAMY, MD, FACC, FHRS / AJAY M. PATEL, MD, FACC, FSCAI

PBM Hx CONSENT

We are updating your consent preferences in our system. **PBM Hx** consent is to allow your provider to review your medications electronically from your pharmacy benefits, which improves the accuracy of your medication list in your electronic chart.

Print Name: _____
(PLEASE PRINT CLEARLY)

Date of Birth: _____

Permission to review my Rx History electronically: ☐ **YES** ☐ **NO**

Signature: _____ Date: _____
I have read the above information and have verified it to be correct.

PBM Hx = Pharmacy Benefit Manager (PBM) History. If you have an Rx Benefit Plan the system will download the medication history from the Pharmacy Benefit Manager (PBM) for your doctor to review your medications.

Notice of Privacy Practices (HIPAA)

This notice is for **Privacy Practices** informing you that we will send documents such as test results and letters regarding your health care provided by CVCHC to your primary care and referring providers. **We will not share your personal health information for any other reason without written consent from you**.

Cardiovascular Consultants Heart Center has made available to me their Notice of Privacy Practices. I am aware that I have the right to a paper copy of this notice.

Signature: _____ Date: _____
I have read the above information and have verified it to be correct.

HIPAA = **HIPAA** (Health Insurance Portability and Accountability Act of 1996) is United States legislation that provides data privacy and security provisions for safeguarding medical information.

Financial Policy

I hereby authorize my insurance benefits to be paid directly to Cardiovascular Consultants of Fresno. I understand that I am financially responsible for all services not covered by my insurance company, which includes my annual deductible.

***If you are an HMO patient, also read and initial this statement:** I am aware that if Cardiovascular Consultants does not receive a referral from my primary care doctor all charges will be my responsibility. *_____ **(Initials)**

Signature: _____ Date: _____
I have read the above information and have verified it to be correct.

This signed document will be scanned to Patient Information in the electronic chart.

(Financial Office Use Only: ☐ **Scanned To Chart)**

Cardiovascular Consultants Heart Center

1207 East Herndon Avenue, Fresno CA 93720

559 - 432-4303 / Fax: 559 - 432 - 4574

KEVIN J. BORAN, MD, FACC, FSCAI / W. EDWARD HANKS, MD, FSCAI / DONALD W. GREGORY, MD, FACC / ROHIT SUNDRANI, MD, FACC, FSCAI
MICHAEL W. GEN, MD, FACC, FSCAI / CHANDRASEKAR PALANISWAMY, MD, FACC, FHRS / AJAY M. PATEL, MD, FACC, FSCAI

Authorization to Disclose Personal Health Information

Patient Name: (Print clearly) _____

Address: _____

Contact Number: _____

Patient Date of Birth: _____

Information will be used for the purpose of: ☐ **Continued Care** ☐ Other: _____

To whom do you want your personal health information released to:

☐ Kevin J. Boran, MD, FACC, FSCAI
☐ W. Edward Hanks, MD, FSCAI
☐ Donald W. Gregory, MD, FACC
☐ Ajay M. Patel, MD, FACC, FSCAI
☐ Rohit Sundrani, MD, FACC, FSCAI
☐ Michael W Gen, MD, FACC, FSCAI
☐ Chandrasekar Palaniswamy, MD, FACC, FHRS
☐

Name and address of the person or organization you are requesting your personal health information released from:

Name / Organization: (Print clearly) _____

Address: _____

Disclosure for:
☐ **Specific Date of Service:** _____
☐ **All Records**

Information is to be:
☐ Mailed
☐ Faxed: (_____) _____
☐ Picked up in person by _____ (Name)

I understand that this authorization:

- Prohibits further use or disclosure of the information being released beyond the specific limits of this consent.
- Includes all medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS), or tests for or infection with Human Immunodeficiency Virus (HIV).
- **Expires in one (1) year from the date of signature.**
- This authorization may be revoked at any time by my written request, effective upon receipt.
- I understand that I have a right to a copy* of this authorization. ***(Copy Requested and Received. Initial Here _____)**

Patient Signature Or Signature of Representative with a copy of Power of Attorney. Note: Legal documentation is required to verify your representation as parent, conservator, guardian or medical decision-making authority for the above patient.

_____ **Date**: _____
Signature of patient or personal representative

_____
Printed name of patient or personal representative with authority to make medical decisions.

CARDIOVASCULAR CONSULTANTS HEART CENTER

1207 EAST HERNDON AVENUE, FRESNO CA 93720

(559) 432-4303

AUTOMATED APPOINTMENT NOTIFICATIONS

Our office uses Automated Appointment Notifications to remind you of your upcoming appointments. You can be notified by Automated VOICE, TEXT message, or EMAIL. Please update all your contact information with our staff as soon as possible and let them know how you would like to be notified of your upcoming appointments. The default Notification will be VOICE until you inform our staff of your notification preference.

Text Notifications are by far the most convenient. All the appointment information is clearly spelled out for you with the date, time and location. All you need to do is reply back to the text **within 24 hours** with the letter **C** which will confirm your appointment, or **X** which will cancel your appointment, or **R** which will request a reschedule of your appointment; otherwise you must call our office.

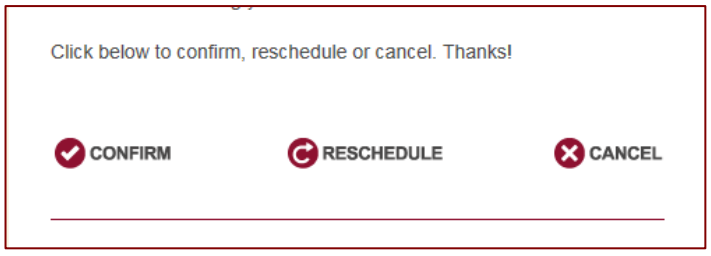
BELOW IS AN EXAMPLE OF HOW THE TEXT MESSAGE WILL LOOK.

THIS IS NOT REAL PATIENT INFORMATION. THIS IS ONLY AN EXAMPLE.

THIS IS ONLY AN EXAMPLE USING A FAKE PATIENT NAMED ABBY.

> Appointment reminder from Cardiovascular Consultants Heart Center. Abby has an appointment with Doctor Boran on 3/21/2017 at 9:30 AM located at our Fresno office. Arrive 15 minutes early. Bring all your medications and current insurance cards. Please notify our office of any insurance changes within 24 hours of this message. Reply C to confirm, R to reschedule or X to cancel.

Email Notifications are also very convenient. You will receive an email with all the appointment information clearly spelled out for you with the date, time and location. The email will contain a **link** to select for **Confirm**, **Reschedule**, or **Cancel**. Please select the appropriate response.



Automated Voice Notifications. You will receive an automated voice message stating the date, time and location of your appointment. You will also be prompted to press **zero** to get to the next menu where you will then be prompted again to press **1** to confirm, press **2** to cancel, or press **3** to reschedule.

The message will repeat two more times until you press zero to get to the next menu. If you miss this call and it goes to voice mail, or if you do not press zero and then press the 1, 2, or 3 to confirm, cancel, or reschedule, you will have to call our office to let us know if you will make it to your appointment.

APPOINTMENT REMINDER

How would you like to be reminded?
Choose as many options as you like!

Name:_____ DOB: _____

Cardiologist:

- ☐ Kevin Boran, MD
- ☐ Donald Gregory, MD
- ☐ Michael Gen, MD
- ☐ Ajay M. Patel, MD
- ☐ Edward Hanks, MD
- ☐ Rohit Sundrani, MD
- ☐ Chandrasekar Palaniswamy, MD

☐ VOICE MESSAGE (_____) _____
Which number is this? ☐ Cell ☐ Home

☐ TEXT MESSAGE (_____) _____

☐ EMAIL (Print clearly) _____

CARDIOVASCULAR CONSULTANTS HEART CENTER

BRING ALL YOUR MEDICATIONS

WE KNOW THAT THINGS COME UP AND SOMETIMES YOU CAN'T KEEP A SCHEDULED APPOINTMENT. PLEASE LET US KNOW IF YOU NEED TO CANCEL AS SOON AS POSSIBLE SO WE CAN OFFER YOUR APPOINTMENT TIME TO ANOTHER PATIENT.

HELPFUL TIPS TO MAKE YOUR APPOINTMENT RUN SMOOTHLY

- **PHONE NUMBERS**
  PLEASE PROVIDE US WITH THE BEST NUMBER TO REACH YOU.
- **UPDATING CONTACT INFORMATION**
  PLEASE UPDATE YOUR ADDRESS AND PHONE NUMBER.
- **CO-PAY**
  PLEASE BRING YOUR CO-PAY AT TIME OF VISIT.
- **PRIMARY DOCTOR INFORMATION**
  LET US KNOW IF YOU HAVE A NEW PRIMARY DOCTOR.
- **APPOINTMENT CONFIRMATION**
  PLEASE CALL US BACK AS SOON AS YOU GET A MESSAGE TO CONFIRM YOUR APPOINTMENT; AT LEAST 2 DAYS PRIOR.
- **MEDICATIONS**
  PLEASE BRING ALL YOUR MEDICATIONS TO EVERY APPOINTMENT FOR YOUR DOCTOR TO REVIEW.
- **INSURANCE INFORMATION**
  CALL OUR OFFICE TO UPDATE INSURANCE INFORMATION PRIOR TO YOUR APPOINTMENT AND BRING YOUR INSURANCE CARDS TO EACH VISIT.
- **TRANSLATORS**
  PLEASE BRING A TRANSLATOR TO YOUR APPOINTMENT IF NEEDED.
- **ARRIVAL TIME**
  PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.
- **OFFICE FORMS**
  COMPLETE ALL FORMS PRIOR TO ARRIVAL FOR YOUR APPOINTMENT.
- **PERSONAL BREAKS**
  PLEASE USE OUR RESTROOM FACILITIES BEFORE OUR MEDICAL STAFF CALLS YOU BACK FOR YOUR APPOINTMENT.

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Notice of Privacy Practices: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to adequate notice of the uses and disclosures of your Protected Health Information ("PHI": information that discloses your identity or leads to disclosure of your identity) that may be made by Cardiovascular Consultants Heart Center. You are also entitled to notice of your rights as well as the duties of this Practice with respect to your Protected Health Information.

Cardiovascular Consultants Heart Center respects your right to privacy and understands that your medical information is personal to you. This Practice strives at all times to maintain the highest degree of integrity in its interactions with patients and the delivery of quality health care. Our practices are based on the sound current philosophy that Protected Health Information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function.

In order to provide medical services to you, we create paper and electronic records about your health and the care we provide. Your Protected Health Information is confidential and this notice is intended to help you understand how our Practice utilizes and discloses your Protected Health Information and what rights you have with respect to your medical information. Cardiovascular Consultants Heart Center and its employees will at all times strive to maintain compliance with all laws, rules, regulations and requirements affecting the practice of medicine and the handling of patient information.

Requirements by Law:
Our Practice has the following duties with respect to your Protected Health Information:

1. We are required by law to maintain the privacy of your Protected Health Information.
2. We must provide you with notice of our legal duties and privacy practices with respect to Protected Health Information.
3. We must abide by the terms of the Notice of Privacy Practices that is currently in effect.

How We May Use and Disclose Your Information
The following describes how our Practice is permitted by law to share your Protected Health Information with others in order to provide you with medical care. This notice does not describe every use or disclosure our Practice makes; it is intended as a general overview.

Medical Treatment:
We may need to use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, we may share information with other physicians, nurses or healthcare professionals to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We may also share information about your including X-rays, prescriptions and requests for lab work to health care providers who become involved in your care.

Payment:
We may need to disclose information about the treatment, procedures or care our Practice provided to you in order to bill and received payment for healthcare services we provided. We may share this information with you, an insurance company or any third party responsible for payment. We may also need to disclose Protected Health Information about you to your health plan and/or referring physician in order to obtain prior authorization for treatment, to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.

Healthcare Operations:
We may use or disclose, as needed, your Protected Health Information in order to help us run our Practice more efficiently and provide better patient care. We may also need to use or disclose your Protected Health Information to Business Associates who need to use or disclose your information to provide a service for our Medical Practice. Our Business Associates could include a billing company, software vendors who provide assistance with data management on our behalf, or transcription services for the Practice.

Required by Law:
We may use or disclose your Protected Health Information to the extent that state, federal or local law requires the use or disclosure.

Public Health Activities/Risks:
Your medical information may be disclosed to a public health authority that is authorized by law to collect or receive such information for public health activities. This disclosure may be made for the purpose of controlling disease, injury or disability. In addition, disclosures may be made for public health activities in the following circumstances:

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1207 EAST HERNDON AVENUE, FRESNO CA 93720
PHONE (559) 432-4303

1. To prevent or control disease, injury, or disability.
2. To report births or deaths.
3. To report child abuse or neglect.
4. To notify report reactions to medications or product defects.
5. To notify individuals of product or drug recalls.
6. To notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
7. To disclose Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies programs and civil rights laws.
8. If our Practice reasonably believes a person is the victim of abuse, neglect, or domestic violence, we may disclose Protected Health Information to the appropriate authority. We will only make this disclosure if you agree to the disclosure or we are required or authorized to do so by law without your permission.

Appointment Reminders or Treatment Alternatives:
Our Practice may use and disclose medical information about you to provide you with reminders that you are due for care or to confirm an upcoming appointment. We may also utilize Protected Health Information to provide you with information or treatment alternatives or other health related benefits that may be of interest to you. We may contract you by phone, by fax or E-mail. We will make very effort to protect your privacy when leaving a message for you and reveal as little confidential information as possible. (i.e. leaving a message on your answering machine that others may hear).

Research:
Under certain circumstances, our Practice may use or disclose your Protected Health Information to researchers when an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information has approved their research. Our Practice may also disclose information about you in preparing to conduct research (i.e., to help them find patients who may be qualified to participate in a particular study), but your information will not leave our Practice. We will make all attempts to make your information non-identifiable, but we may not always be able to guarantee this. If however, the researcher will have access to information that will identify you, we will seek to obtain your permission (though we cannot guarantee this). We will always obtain your specific authorization if required by law.

To Avert Serious Threat to Health or Safety:
If in good faith, our Practice believes that a use or disclosure of your medical information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, we may disclose your medical information.

Workers' Compensation:
We may disclose your Protected Health Information as authorized to comply with Workers' Compensation laws and other similar legally established programs.

Health Oversight Activities:
Your Protected Health Information may be disclosed to Federal, State or Local authorities as part of an investigation or government activity authorized by law. This may include audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions or other activities necessary for the oversight of the health care system, government benefit programs and compliance with government benefit programs and compliance with government regulatory programs or civil rights laws.

Law Enforcement:
We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes. We may also disclose medical information about you in compliance with a court order, warrant or subpoena or summons issued by the court. We may also use such information to defend us in actions or threatened actions that may be brought against our Practice.

Coroners, Medical Examiners and Funeral Directors:
We may release Protected Health Information to a coroner or medical examiner for the purposes of identification, determining the cause of death, or other duties authorized by law. We may also release medical information to funeral directors as necessary to carry out their duties with respect to the deceased.

Organ, Eye and Tissue Donation:
If you are an organ donor, Protected Health Information may be disclosed to organ procurement organizations or other entities that facilitate tissue donation or transplantation.

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Inmates:
If you are an inmate of a correctional institution or within the custody of law enforcement officials, we may disclose medical information about you to allow the institution to provide you with medical care, to protect the health and safety of yourself and others, or for the safety and security of the correctional institution. *Other uses and disclosures will be made only with your written authorization and you make revoke your authorization at any time.

PATIENT'S RIGHTS You have the following rights with respect to your Protected Health Information:

Right to Receive Personal Health Information Confidentially.
You have the right to receive confidential communications of your Protected Health Information by alternate means or at alternate locations. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. For example, if you would like for us only to communicate with you at home, and never at your workplace or to send information to you on you workplace e-mail, you may request this of our Practice. You must make this request in writing but do not need to disclose the reason for your request. We will attempt to accommodate all reasonable requests. Please be specific as to how or where you wish us to communicate with you.

Right to Inspect and Copy.
You have the right to inspect and copy your medical record that has been created to treat you and is used to make decisions about your care. This includes medical and billing records. Records related to your care may also be disclosed to an authorized person such as a parent or guardian upon proper proof of a legitimate legal relationship. You must submit your request in writing to inspect and copy your records. If you would like to copy your records, mail or other minimal costs associated with your request.
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to a law that prohibits access to Protected Health Information. Depending upon the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if your have questions about access to your medical record.

Right to Amend.
If you think there is information in your record that may be inaccurate or incomplete, you have the right to request an amendment or clarification. Your request to make an amendment to your record must include the following and may be refused if the following elements are not met:

1. You must submit your request for an amendment in writing.
2. Your request should describe what you would like the amendment to say and your reasoning for why the change should be made.
3. The amendment must be dated, signed by you and notarized.

In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please note that we will not change information created by third parties, if the information is not part of the medical information kept by our Practice or we believe the information you provided to us is inaccurate or incomplete. We reserve the right to deny your request if we have reason to believe the information is accurate.

Right to Restrict Uses and Disclosures.
You have the right to request restrictions on how our Practice makes certain uses and disclosures of your Protected Health Information for treatment, payment or healthcare operations. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may be involved in your care. You may also restrict certain types of marketing materials related to your care or treatment. Your request must be in writing and include the following:

1. The information that you would like us to limit.
2. Whether your want to limit our use or disclosure or both
3. To whom you want the limits to apply (i.e. disclosures to parents, children, spouse, etc.

Your physician is not required to agree to a restriction that your may request. If your physician believes it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

Right to an Accounting of Uses and Disclosures.
You have the right to receive an accounting of the disclosures of your Protected Health Information that our Practice makes for purposes other than treatment, payment or healthcare operations. All requests must be submitted in writing. You have the right to received specific information regarding these disclosures that occurred after April 14, 2003. One request in a twelve-month period will be provided to you at no charge. We may charge you a fee for all additional requests within a twelve-month period. We will notify you as to the cost of fulfilling your additional request and provide you with the opportunity to modify it before fees are due.

CARDIOVASCULAR CONSULTANTS HEART CENTER
1207 EAST HERNDON AVENUE, FRESNO CA 93720
PHONE (559) 432-4303

Right to Copy of Notice.
You have a right to obtain a copy of our Notice of Privacy Practices upon request at any time. Please call us at (559) 432-4303. You may also request a copy at the reception desk.

Changes to this Notice.
Cardiovascular Consultants Heart Center is required to abide by the terms of this notice, which is currently in effect. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information we already have about you and may obtain in the future. If we change our notice, we will post notice of this change 30 days prior to making the change effective. The Notice will be posted in our offices. All revised notices will be promptly posted and made available to your in our waiting room. You may also request a current Notice when you visit our office. Changes to our notice will only be effective on the date that is reflected at the bottom of the last page on the revised Notice.

Practice Contact.
If you would like more information about this Notice, please contact the Office Manager, **Susan Morrow**, if you have any complaints regarding our Privacy Practices, please address your complaint to the Office Manager in writing and follow the designated complaint process below.

Complaints.
If you believe your privacy right may have been violated or you become aware of a privacy concern you would like to report to our practice, please follow the complaint practice outlined below:

1. Send a written letter to the practice contact named above, including the following information:
    a. Name and Address
    b. Social Security Number or Patient Identification Number.
    c. A detailed description of the circumstances surrounding your complaint including the dates, times and any other relevant information that will help us to understand your complaint.
    d. Contact information
    e. Signature and Date

2. Please allow 14 business days for an answer from our practice regarding your complaint.
3. If you are not satisfied with our response to your complaint, you may notify the secretary of the Department of Health and Human Services.

Please note, all concerns or complaints regarding your Protected Health Information are important to our Practice. There will be not retaliation against you for filing a complaint with our office.

Additional Privacy Protections.
Our practice is committed to protecting your privacy and the proper usage and disclosures of your Protected Health Information.