



333 North 1st Street, Suite 280
Boise, ID 83702
208-345-6545

PATIENT INFORMATION AND CONSENT

Date _____ Doctor _____ Account # _____

Last Name _____

Social Security # _____

First Name _____

Sex _____ (M)ale (F)emale

Address _____

Marital Status:

Single Married Divorced Separated Widow Minor

City _____ State _____ Zip _____

Home Phone () _____

Employer _____

Work Phone () _____

Family Physician _____

Cell Phone () _____

Referring Physician _____

e-mail _____

Emergency Contact _____

Date of Birth _____

Relationship _____ Phone _____

If married, Spouse's Name _____

BILLING INFORMATION

Do you have medical insurance? Yes No

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

Name _____

Name _____

Address _____

Address _____

ID # _____

ID # _____

Group # _____

Group # _____

Subscriber _____

Subscriber _____

Birth Date _____

Birth Date _____

Responsible Party _____

Phone _____

As patient or legal guardian of patient, I agree to be fully responsible for all charges for services rendered. I authorize my doctor or his agent to submit claims to Medicare or my insurance carriers for charges incurred. I authorize my Medicare or insurance benefits to be paid directly to the doctor. I understand that there is a possibility of non-coverage by my insurance companies or Medicare. If they determine that any service is deemed "medically unnecessary" I agree to assume responsibility for denied payment. I further authorize this office to obtain and release my medical records to and from other physicians. Medical facilities, insurance companies and Medicare to facilitate my health care and appropriate payments.

Signature _____

Date Signed _____

Name _____

Age _____

MEDICAL HISTORY

Do you now or have you ever had any of the following (circle):

Heart disease

Bleeding disorders

Stomach ulcers

High blood pressure

History of blood clots

Lupus

Diabetes

Asthma

Arthritis

Have you ever worn prescription strength compression stockings? Yes No Duration: _____

Do you have any medical conditions not listed above? (Please explain)

SURGICAL HISTORY

Operation

Year

Operation

Year

FAMILY HISTORY

Do any members of your immediate family have, now or in the past, any of the following conditions?

High blood pressure

Relationship

Heart disease

Stroke

Diabetes

Varicose Veins

Blood clots in legs or lungs

History of anesthetic complications

PERSONAL HABITS

Have you ever smoked? Yes No

of years smoked? _____

of packs per day _____

of years since you quit? _____

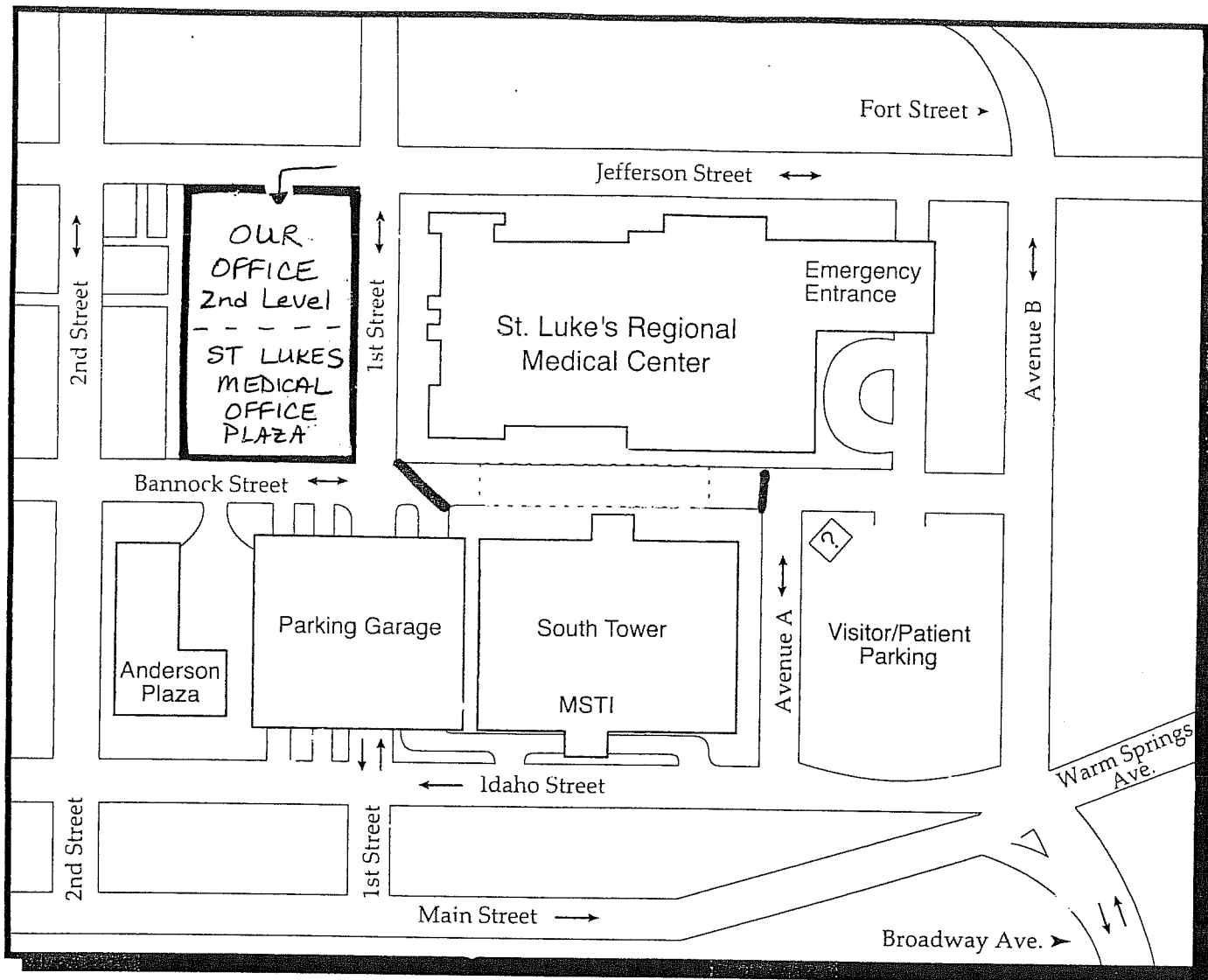
Do you regularly drink alcohol? Yes No

Beer/Wine: _____ drinks per week

Liquor: _____ drinks per week

Occupation: _____

Where to find us



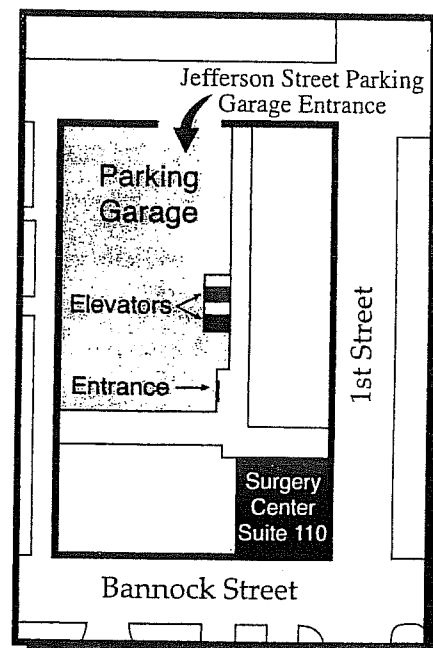
CARDIOTHORACIC & VASCULAR ASSOCIATES

333 N 1st, Suite 280
Boise, ID
345-6545

We are located in the St. Luke's Medical Office Plaza and garage entrance is from Jefferson Street.

DIRECTIONS:

From the west, take City Center exit to Broadway. From the east, take Broadway exit. Continue north on Broadway to Jefferson Street and turn left. Cross 1st Street, get into left lane and turn left into Parking garage. Go to second level.





CARDIOTHORACIC & VASCULAR ASSOCIATES FINANCIAL INFORMATION

As a courtesy to you, CVA will file your insurance claim for you. Please make sure we have all your correct information on file when you check in for each visit, along with any referrals that may be required by your insurance company.

Please remember that certain insurance policies require pre-certification and/or second opinions for some tests, so checking with your insurance provider to be sure of their policies is always advised.

Please be prepared to pay any co-pay and/or deductibles required by your insurance company at the time of your service. After your insurance company responds to your claim, you will be billed for any balance on your account. As a convenience, you may pay by cash, personal check, debit card or credit card from Visa, MasterCard or Discover.

If you are unable to pay your account in full within 90 days from the date of service for all services provided, please contact our in office Patient Financial Services for possible payment arrangements on your account.

If you do not have insurance and are paying out of pocket, please contact us immediately. We will be happy to work with you to find a solution.

Our business office is open Monday through Friday, 8 AM – 5 PM, Mountain Time

For further information please contact:

**CVA
Patient Financial Services
333 North 1st St #280
Boise, ID 83702**

208-342-1108

Notice of Privacy Practices
Cardiothoracic & Vascular Associates

Effective Date: April 14, 2003

To our patients:

This notice describes how health information about you, our patient, may be used and disclosed, and how you can get access to your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our medical practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information and must provide you with the following important information:

We will primarily use your health information that we keep to provide you with the medical care that you need. For example, a doctor may use information in your medical record to diagnose or treat your condition. We will also use it to complete the billing and collection cycle for fees charged in association with that care. For example, we may disclose information to your medical insurance company when we submit a claim for you.

We may, and in some cases must, use or disclose your health information without your written authorization:

1. to carry out our healthcare operations. For example, we may use your health information to review performance or qualifications of our medical personnel.
2. to avert a serious threat to the health and safety of others.
3. to report to appropriate government agencies health information regarding the abuse or neglect of a child.
4. to report to appropriate government agencies the health information regarding certain communicable diseases or that which is needed to prevent or control disease or injury or to compile vital statistics.
5. to respond to a court subpoena request or other lawful process if we have received satisfactory assurances from the requestor that they have made efforts to inform you of the request or have obtained a protective order.
6. to provide law enforcement officials with assistance regarding the identity or location of a suspect, fugitive or material witness, or to provide information about a victim or a crime, or to assist with national security issues.
7. to aid a coroner in identifying a deceased person or to determine the cause of death.
8. to allow a funeral director to carry out their duties.
9. to aid those authorized to procure transplant organs.
10. to participate in medical research when appropriate steps have been taken to protect the information.
11. to allow the Workmen's Compensation laws to be administered.
12. to contact you in order to provide appointment reminders or to provide information about treatment alternatives.
13. to allow our business associates to perform billing, transcription and other services necessary to run our medical practice.
14. to disclose as required by military command authorities if you are a member of the military.

We may use or disclose your health information when we feel it is necessary, unless you have specific objections, to other persons involved in your healthcare. For example, those persons may be your family

members, your relatives, your close friends, your clergymen or other persons identified by you as being involved with your care.

We will obtain your written authorization to use or disclose your health information in situations not mentioned above. You may revoke a written authorization by submitting a written notice to the Privacy Contact mentioned below.

Your Rights Regarding Your Protected Health Information

1. You may request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You may request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, or in emergencies, or when the information is necessary to treat you.
3. You may inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Contact (please see below) on a form provided by us.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing to the Privacy Contact (please see below) on a form that we will provide for you. You must provide us with a reason that supports your request for amendment. We are not required to agree to your request.
5. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with our practice, contact the Privacy Contact (please see below). All complaints must be submitted in writing on a form provided by us. We will not penalize or retaliate against you for filing a complaint.
6. You have the right to give our medical practice your written authorization for uses and disclosures that are not identified by this notice or that are not permitted by law without a written authorization. The Privacy Contact (please see below) will determine if the form of the written authorization is appropriate for the request.
7. You have the right to receive an accounting of certain disclosures we have made of your protected health information after April 14, 2003. You may obtain the first accounting within a 12-month period free of charge. We may charge you a reasonable cost-base fee for all subsequent requests.
8. You have the right to be given a paper copy of this Notice upon request.

Privacy Contact

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Contact at Cardiothoracic & Vascular Associates.

Current Privacy Contact: Health Information Coordinator
333 N. 1st Street #280
Boise, ID 83702
(208) 345-6545