
**Patient Information**

**Patient Name:** **Mailing Address:**
**Home Phone:** **Work Phone:**
**Cell Phone:** **E-mail Address:**
**Date of Birth:** **Age:** **SSN:**
**Employer Name:**
**Employer Address:**
**Employer Phone Number:**
**Marital Status:**

**Emergency Contact Information**
**Name:**
**Relationship to Patient:**
**Home Phone:** **Cell Phone:** **Work Phone:**

**Insurance Informati**
**Primary Insurance Carrier:** **Secondary Insurance Carrier:**
**Subscriber:** **Subscriber:**
**Subscriber's DOB:** **Subscriber's DOB:**
**Primary ID:** **Secondary ID:**
**Primary Group:** **Secondary Group:**
**Please make sure to give ALL of your insurance information to the front desk**
**Physician Information:**
**Primary Care Physician:** **Referring Physician:**
**Address:** **Address:**
**Phone:** **Phone:**
**Fax:** **Fax:**

**Pharmacy:** **Pharmacy Address:**

**Pharmacy Phone:** **Pharmacy Fax:**

**Please sign by the X**
I hereby assign Pinnacle Heart Specialists, LLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking this authorization. I acknowledge that all charges are to be paid at time of service unless I present a valid insurance card. All insurance co-pays, deductibles, and non-covered services are also expected to be paid at time of service. In the event I am unable to come to my appointment or I am more than 30 minutes late and do not inform Pinnacle Heart Specialists, I will be charged a self-pay late fee of $30.00 as well as be rescheduled for a future date. I also understand that if my insurance carrier does not pay my claim within 90 days of the billing date, I assume full financial responsibility. Any unpaid balances over 90 days on my behalf will also be considered for further collection action. If I fail to meet these obligations, I will be responsible for collection fees of up to 40%, attorney fees, and court costs to effect collection of this account or future outstanding accounts. I will also be responsible for a $25.00 returned check fee and/or failed credit card transaction. I authorize the release of any medical information from other healthcare providers and/or healthcare facilities to Pinnacle Heart Specialists that is needed during the course of my care. This shall remain valid until written notice is given by me to the office revoking this authorization.You may be referred to one or more providers of Jovic Primary Care & Walk-in Clinic (the “Jovic Clinic”) for services. Because the Jovic Clinic is an operating division of Pinnacle Heart Specialists, the referring physician has a financial interest in the Jovic Clinic. You are free to choose any health care entity you wish for obtaining services that may be ordered or requested for you by any physician of Pinnacle Heart Specialists. Your physician would be happy to discuss alternatives with you. By signing below, you acknowledge that you have been informed of your choice to be referred to another health care entity

X_____
Patient Signature Date

1935 N Capitol Ave, Suite 200
Indianapolis, IN 46202
Phone: 317-931-3252
Fax: 317-931-3255

## HIPAA CONTACT FORM

**Preferred Method of Contact:**_____**Home Phone** _____**Cell Phone** _____**Email**

**Patient Home: May we leave a message?** _____**Yes** _____**No**

**Patient Work: May we leave a message?** _____**Yes** _____**No**

**Patient Cell: May we leave a message?** _____**Yes** _____**No**

**Can We Email You?** ___ **Yes** __ **No**

**If yes, please list your email address:** _____

**Who may we talk to on your behalf about your medical issues?**

**Name:**_____**Name:**_____
**Relationship:**_____ **Relationship:**_____
**Telephone Number:**_____**Telephone Number:**_____

**Name:** _____**Name:**_____
**Relationship:**_____**Relationship:**_____
**Telephone Number:**_____**Telephone Number:**_____

**Who may we talk to on your behalf for billing issues?**

**Name:**_____**Name:** _____
**Relationship:**_____**Relationship:**_____
**Telephone Number:**_____**Telephone Number:**_____

**Name:**_____**Name:**_____
**Relationship:**_____**Relationship:**_____
**Telephone Number:**_____ **Relationship:**_____

**Print Name:**_____ **Date of Birth:**_____

**Signature:** _____**Date:** _____

# Do I Need a Test for CVI?

***Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects over 2.5 million Americans, most over the age of 40. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, smoking, standing or sitting for long periods of time and not getting enough exercise. Answers to these questions will determine if you are at risk for CVI and if a vascular exam will help us better assess your vascular health status.***

Name:_____ Date:_____

| ***Circle "Yes" or "No":*** | | | | **Test for Venous Disease** |
|---|---|---|---|---|
| 1. | Are your legs swollen, painful, red or warm to the touch? | Yes | No | ☐ |
| 2. | Have you had a blood clot in a vein that caused inflammation, pain or irritation? | Yes | No | ☐ |
| 3. | Do you have varicose veins (veins that are enlarged or swollen and raised above the surface of the skin) in the legs? | Yes | No | ☐ |
| 4. | Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, cellulites, or non-healing ulcers? | Yes | No | ☐ |
| 5. | Do your legs feel heavy, tired, restless or achy? | Yes | No | ☐ |
| 6. | If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple? | Yes | No | ☐ |
| 7. | If your feet, ankles and legs are swollen, does the skin look stretched or shiny? | Yes | No | ☐ |
| 8. | Do you have an ulcer on the inside of your ankle? | Yes | No | ☐ |

Patient Signature:_____

Physician Signature:_____ Date :_____

# Do I Need a Test for PAD?

***Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.***

Name:_____ Date:_____

## *Circle "Yes" or "No":*

| | | | | **Test for PAD** |
|---|---|---|---|---|
| 1. | Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? | Yes | No | ☐ |
| 2. | Do you experience any pain at rest in your lower leg(s) or feet? | Yes | No | ☐ |
| 3. | Do you experience foot or toe pain that often disturbs your sleep? | Yes | No | ☐ |
| 4. | Are your toes or feet pale, discolored, or bluish? | Yes | No | ☐ |
| 5. | Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? | Yes | No | ☐ |
| 6. | Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? | Yes | No | ☐ |
| 7. | Have you suffered a severe injury to the leg(s) or feet? | Yes | No | ☐ |
| 8. | Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? | Yes | No | ☐ |

Patient Signature:_____

Physician Signature:_____ Date :_____

# Pinnacle Heart Specialists

## NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (ITHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice conceming your ITHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

e How we may use and disclose your ITHI . Your privacy rights in your ITHI e Our obligations concerning the use and disclosure of your THI

The terms of this notice apply to all records containing your ITHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices ina visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Privacy Officer : 1935 N. Capitol Avenue, Suite 200, Indianapolis, Indiana 46202 317-931-3252

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IHD IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

Treatment, Our practice may use your ITHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the wesults to help us reach a diagnosis. We might use your ITHI in order to write a prescription for you, or we might disclose your [THI to a pharmacy when we order a prescription for you. Many of the people who work for our practice — including, but not limited to, our doctors and nurses — may use or disclose your IIHI in order to treat you or to assist others in your treatment, Additionally, we may disclose your ITHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your I[HI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your ITHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are cligible for bencfits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your ITHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IH to bill you directly for services and items. We may disclose your ITHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health Care Operations. Our practice may use and disclose your IJHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your ITH] to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your ITHI to other health care providers and entities to assist in their health care operations.
4. Appointment Reminders. Our practice may use and disclose your ITHI to contact you and remind you of an appointment. We may leave a message on your answering machine if we cannot talk to you personally. We may also send you a postcard or letter if you miss an appointment.
5. Treatment Options. Our practice may use and disclose your [HI to inform you of potential treatment options or alternatives,

6. Health-Related Benefits and Services, Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may release your [THI to a friend or family member that is involved in your care, or who assists in taking care of you. For

   Example, a relative or guardian may ask that a relative/friend take a patient to the cardiologist office for treatment. In this example, the relative/friend may have access to this patient's medical information. A custodial parent and noncustodial parent of a child have equal access to the parents' child's health records. This applies generally for patients under the age of 18 provided that the patient is not married or emancipated or for certain circumstances provided for by Indiana State Law. Our practice may not allow a noncustodial parent access to the child's health records if: (1) a court has issued an order that limits the noncustodial parent's access to the child's health records; and (2) the provider has received a copy of the court order or has actual knowledge of the court order.
8. Disclosures Required By Law. Our practice will use and disclose your ITHI when we are required to do so by federal, state or local law. a USE AND DISCLOSURE OF YOUR ITHI IN CERTAIN SPECIAL CIRCUMSTANCES 'The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

   1, Public Health Risks, Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for purposes such as:

- maintaining vital records, such as births and deaths reporting child abuse or neglect preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information ® notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your ITHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.

   We also may disclose your ITHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the information the party has requested,
4. Law Enforcement. We may release ITHI if asked to do so by a law enforcement official:

   Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement

   Concerning a death we believe has resulted from criminal conduct

   Regarding criminal conduct at our offices

   In response to a warrant, summons, court order, subpoena or similar legal process

   To identify Aocate a suspect, material witness, fugitive or missing person

   In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. Deceased Patients. Our practice may release ITHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. Health records of a deceased patient may be requested by the personal representative of the patient's estate.
6. Organ and Tissue Donation. Our practice may release your [THI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. | Research. Our practice may use and disclose your [HI for research purposes in certain limited circumstances, We will obtain your written authorization to use your ITHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

(i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be pemmitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practi cancer patients. If you have a pacemaker or implantable cardiac defibrillator we may release IIHT to the manufacturer of the device in their status reports.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your ITHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHT to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose your ITHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or t a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Privacy Officer, Pinnacle Heart Specialists, 1935 N. Capitol Avenue, Suite 200, Indianapolis, Indiana 46202, 317-931-3252, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your [IHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI 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, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your ITHI, you must make your request in writing to: Privacy Officer, Pinnacle Heart Specialists, 1935 N. Capitol Avenue, Suite 200, Indianapolis, Indiana 46202, 317-931-3252. Your request must describe in a clear and concise fashion:

(a) _ the information you wish restricted;

(b) whether you are requesting to limit our practice's use, disclosure or both: and

(c) to whom you want the limits to apply.

5. Inspection and Copies. You have the right to inspect and obtain a copy of the ITHI 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: Medical Records Clerk, Pinnacle Heart Specialists, 1935 N, Capitol Avenue, Suite 200, Indianapolis, Indiana 46202, 317-931-3252, in order to obtain a copy of your IIH. Our practice will charge

a fee approved by the State of Indiana for the costs of copying, mailing, labor and supplies associated with your request. A copy of the" Charges Permitted for Providing Copies of Medical Records" is available upon request, Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial, Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice, To request an amendment, your request must be made in writing and submitted to Privacy Officer, Pinnacle Heart Specialists, 1935 N. Capitol Avenue, Suite 200, Indianapolis, Indiana 46202, 317-931-3252, You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the ITHI kept by or for the practice; (c) not part of the ITHT which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non- routine disclosures our practice has made of your [HI for non-treatment, non-payment or non-operations purposes. Use of your ITHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Privacy Officer, Pinnacle Heart Specialists, 1935 N. Capitol Avenue, Suite 200, Indianapolis, Indiana 46202, 317-931-3252. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices, You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Privacy Officer, Pinnacle Heart Specialists, 1935 N. Capitol Avenue, Suite 200, Indianapolis, Indiana 46202, 317-931-3252.

T. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Privacy Officer, Pinnacle Heart Specialists, 1935 N, Capitol Avenue, 'te 200, Indianapolis, Indiana 46202, 317-931-3252. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our ptactice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your ITHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIH for the purposes described in the authorization, Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Privacy Officer, Pinnacle Heart Specialists, 1935 N. Capitol Avenue, Suite 200, Indianapolis, Indiana 46202, 317-931-3252.


**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**WRITTEN ACKNOWLEDGE FORM.**

I,_____, have received a copy of

Patient Name

Pinnacle Heart Specialists Notice of Privacy Practices.

_____ _____

Signature of Patient Date

_____ _____

Witness Signature Date