Shane B. Darrah, MD, FACC
Akram Ibrahim, MD, FACC
Jed Vickers, PA-C
Laura Rue, NP

Sheri Lopez, MD, FACC
Hunter Champion, MD, PhD, FAHA
Kyle Cullefer, NP

NOTICE OF HIPAA POLICIES AND PATIENT ACKNOWLEDGEMENT FORM

I acknowledge that SEC follows the guidelines set forth by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that the practice may use my personal health information to help provide health care to me with regards to billing and payment and/or other health care options. There may be no other uses or disclosures of this information unless I permit. I do, however, understand that sometimes the law may require the release of this information without my permission. I also understand that my health information is private and confidential. I understand that Southeastern Cardiology Associates will strive to protect my privacy and preserve the confidentiality of my personal health information. I understand that SEC has established procedures that help them in protecting my personal health information. These procedures may include other signature requirements, written acknowledgement, authorizations, and reasonable time allowance for requested information. I understand there may be charges incurred for copying my health information and for non-routine information needs. I further understand that SEC will not use or disclose my health information without my authorization, except as described in this notice.

My signature below indicates that I understand and agree with the above use of my protected health information and that I have received a copy of the HIPAA Privacy Rule.

My signature below authorizes Southeastern Cardiology Associates to obtain any medical records necessary to assist with the medical care of my behalf.

_____ _____

Signature **Date**

2121 Warm Springs Road
Columbus, GA 31904
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www.southeasterncardiology.com

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Alternative Communication Release Form

I authorize Southeastern Cardiology Associates in regards to my protected health information:

_____To speak with anyone listed on the Right to Share Information list, and to give my prescriptions to them as indicated below.
_____To speak only with me.

Right to Share Information with Family and Friends

Southeastern Cardiology Associates reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of HIPAA Policies.

In order to have your PHI shared in other circumstances with members of your family or friends, please list those individuals that we are authorized to release information to.

	Is Allowed to Pick up Prescriptions	
_____ **Name**	Yes	No
_____ **Name**	Yes	No
_____ **Name**	Yes	No
_____ **Name**	Yes	No

_____ **Patient Name (printed)**

_____ **Date of Birth**

_____ **Signature of Patient**

_____ **Date**

_____ **Signature of Witness**

_____ **Date**

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CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

IMPORTANT: Do not sign this form without reading and understanding its contents. Mark out and initial any Procedure and/or section of this form for which consent is not granted.

During the course of my care and treatment, I understand that various types, diagnostic, or treatment procedures may be necessary. These procedures are performed by the physician or an assistant for the physician.
While usually performed without incident, there are potential risks associated with each of these procedures. It is not possible to list every risk for every procedure and this form will therefore list the most common possible risks. It is important to note that a simple act as taking a commonly used medication can rarely cause severe reactions that could lead to organ failure or even death.
If I have any questions or concerns regarding these procedures, I will ask my physician or his/her assistant to provide me with additional information. These procedures include:

- Needle sticks such as shots, injections, or intravenous lines to administer fluids or medications. Material risks include, but are not limited to infection, infiltration (fluid from an IV leaking into tissue), disfiguring scar, nerve damage with possible loss of limb function. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
- Physical tests, assessments and treatments such as internal body examinations, wound cleaning and wound dressing. Material risks include allergic reaction and infection. Apart from using modified procedure and/or refusal of treatment, no practical alternative exists.
- Drawing blood or bodily fluids with a needle or taking tissue samples (biopsy). Material risks include but are not limited to infection, damage to joint or organ, nerve damage, and bleeding.
- Administration of medication whether orally, rectally, topically, or through the eye, ear, or nose. Material risks include, but are not limited to, allergic reaction, puncture, and perforation. Apart from varying the method of administration and/or refusal of treatment, no practical alternative exists.
- Insertion of internal tubes such as scopes, catheters, drainage tubes, etc. Material risks include but are not limited to internal injuries, bleeding, infection, and difficulty urinating after long term catheter placement. Apart from external collection devices or refusal of treatment, no practical alternative exists.

I understand that:

- The practice of medicine is not an exact science and that NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any procedures; and
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the procedures, therefore, I agree to provide accurate and complete information about my medical history
- I may be asked to sign additional required informed consent documents for specific procedures and tests. By signing this form:
- I consent to Healthcare Professional performing Procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen and not known to be needed at the time this consent is obtained; and
- I acknowledge that I have been informed, in general terms, of the nature and purpose, the material risks and the practical alternatives of the procedures.

I understand that SEC uses a Physician's Assistant, Jed Vickers, PA-C, Nurse Practitioners Erin K. Cullefer, NP and Laura Rue, NP in our office for those levels of practice that have been approved by the Georgia State Board of Medical Examiners. Your Signature on this approval form conveys that you are in agreement with being treated by our mid-levels whom act under our supervision.

_____

Signature **Date**

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Southeastern Cardiology Associates, P.C.

Financial Policy

Effective June 1, 2016

- As a courtesy to our patients, we file insurance on behalf of the patient. It is the **patient's responsibility** to make sure that the practice has the correct insurance information. If the patient does not provide the practice with the appropriate information so that the bills can be submitted to insurance within 30 days then the bill becomes the responsibility of the patient.
- **The patient is** responsible for obtaining all referrals for office visits and testing prior to your visit. The practice will assist whenever possible.
- **The patient will be responsible for all co-payments, co-insurances and deductibles.**
- If after 60 days your insurance company has not processed the claim, it will become the **patient's** responsibility and they will receive a bill for the services.
- **We will bill the patient for any balances due (co-insurance and deductibles) and expect all accounts to be paid within the initial billing cycle.** A 2% monthly service fee will be assessed for unpaid balances after 60 days (2 billing cycles).
- If you are unable to pay your balance in full, please contact our billing office at **706.221.6116** to make payment arrangements. This plan will require a regular monthly payment and must be paid in full according to the payment plan structure (see Payment Arrangement Policy). If a payment is missed, the account will default to the collection process.
- This practice sees all patients regardless of ability to pay. Discounts for essential services are offered depending upon family size and income. You may inquire about this with the front desk.
- **Accounts not paid in full after the second billing cycle and without an arranged payment plan with our billing office will be put into the collection process.** A 25% service fee will be added to all accounts sent to a collection agency.
- We participate with most insurance plans. However, it is the responsibility of the patient to know which providers are with their insurance plan. We are happy to assist in determining if we are on your provider panel.
- A **$25.00 charge** will be assessed for any appointment not cancelled within 24 hours of the scheduled appointment time.
- There will be a **$35 charge assessed for any echo or vascular appointment** a **$100 charge assessed for any stress test appointment and $50 for any treadmill appointment** that is not canceled within 24 hours. This fee must be paid before you can reschedule.
- A $35.00 charge will be assessed for any check returned from the bank.
- There is a $50.00 charge for the completion of any forms.
- A charge of $.25 per page will be assessed for a copy of medical records that exceeds 10 pages and an additional charge of $2.00 will be assessed if the medical records need to be notarized.

Please sign below indicating that you have read and agree to our Financial Policy.

Patient Name (please print) _____

_____ _____

Patient Signature or Guardian Date

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HIPPA COMPLIANT AUTHORIZATION FOR THE RELEASE/DISCLOSURE OF PHI

FOR SEC STAFF USE ONLY:

TO: _____ FAX: _____

PLEASE SEND REQUESTED INFORMATION:

_____

_____

FOR PATIENT USE:

PATIENT NAME: _____DOB: _____ LAST 4 SSN: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the facility where PHI is being requested from. I understand that my revocation is not effective to the extent that persons or organizations in which I have authorized to use and/or disclose my PHI have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility of benefits. I understand that I will be given a copy of this authorization upon my signature, when requested. I hereby authorize the facility where I am requesting PHI to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I hereby release the facility where I am requesting PHI from any liability which may result from this disclosure of confidential medical information of which may arise of the result of the use of information contained in the information released. I authorize this information may be faxed when applicable. I agree to pay copy charges if applicable.

PATIENT SIGNATURE: _____

SEC WITNESS: _____ DATE: _____

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted disease; human immunodeficiency (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

SPECIFIC INFORMATION NOT TO BE DISCLOSED: _____

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Testing Cancellation Policy

Our office requires a MINIMUM of 24-hour notice on a cancellation. You will be billed $35 to $100 (depending on the test) for cancellations that fall outside the 24-hour cancelation window and missed appointments. Please note that insurance companies do not reimburse for cancelled appointments. You will not be permitted to reschedule your appointments until this fee has been paid.

I have read the above policy and understand I will be charged a fee if I do not give the required notice for cancellation.

Patient Signature: _____
SEC Witness: _____

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