New Patient
Intake Package

At St. Louis Vascular Surgical Specialists ("SVSS"), our goal is to help you achieve the best quality of life possible. To provide you with the best possible care and experience, we ask you to complete the enclosed forms to bring with you to your first visit:

1. Patient Demographics (Pages 4 to 5)
2. Medical History (Pages 6 to 9) *will be completed with your nurse*
3. Acknowledgment of Conditions (Page 10)
4. Patient Treatment and Financial Agreements (pages 11 to 15)
5. Notice of Privacy Practices and HIPAA Signature form (pages 16 to 20)
6. Potential Exposure to Radiation (page 21)

While filling out those forms, please also:

- Think through your entire medical history, including past medical problems, symptoms, surgeries, treatments, medications, and hospitalizations.

- Evaluate your current and past lifestyle and habits, including eating or drinking habits, as well as how much you sleep, exercise, or smoke.

- Consider why you are seeing us. What health concerns would you like to discuss with your provider? What do you think your provider should know about you or your health to provide you with the best care possible?

As our patient:

We expect that you are serious about and dedicated to improving your health. Unfortunately, even with our care, you are *unlikely to get better* if you do not take an active role in your health and make the necessary lifestyle changes. With that in mind, here are some helpful tips and guidelines regarding our expectations for you as our patient:

- We expect open and honest communication with your provider.

- You will ask your provider any questions you have about your health or medical care, such as about any diagnoses you may have, potential treatments (including surgeries or medications), and what can you do to help keep your symptoms from getting worse or recurring. If you do not understand something, ask your provider to explain it.

- You will keep us up to date regarding your health and medical care. For examples, we need to know if you develop a new problem or new symptoms, if your symptoms get worse or change, if you see another doctor, if you have a surgery, if you are hospitalized, or if your medications have changed.

- You will follow your provider's plan of care. It is vital that you keep your medical appointments, take your medications as prescribed, and otherwise follow what your provider recommends for your plan of care, including making lifestyle changes and

practicing self-management. If you have trouble complying with your plan of care for any reason, you will truthfully tell us what issues you are having and actively seek our assistance.

- You will educate yourself. You will read all educational materials that we provide to you, which are also available on our website, which is www.stlvascular.com. In addition to our website, we recommend the following websites:

    - Society of Vascular Surgery: https://vascular.org
    - American Medical Association: https://www.ama-assn.org

- If you smoke, you will stop smoking. Smoking can cause or worsen many of the diagnoses that we see in our practice. *It is extremely unlikely that you will get better if you do not stop smoking*. You will live longer if you stop smoking. We provide resources on kicking the habit on our website, which we encourage you to use.

- You will eat healthier and exercise. Excess weight can cause or worsen many of the diagnoses that we see in our practice. By eating a proper diet and exercising, you lessen the risk that your diagnosis/es will get worse. We provide resources on nutrition and exercise on our website, which we encourage you to use.

To communicate with our office, please call us at (314) 755-1084 or visit our website www.stlvascular.com.

Because we aim to exceed your expectations, to the extent that you have any grievance or concerns regarding your care, we ask you to let us know about it so that we can address it. Please contact us at (314) 755-1084 to initiate our internal grievance process. We also welcome any suggestions that you may have.

Please bring the following to your first visit:

1. All completed forms in this packet
2. Your driver's license or other photo identification
3. Your health insurance card(s)
4. Many insurance plans require a referral prior to being seen by a specialist such as us. Please confirm and bring your referral as you cannot be seen without it.
5. Co-payment as it will be collected prior to any services being rendered.

Thank you for your time and patience in completing our New Patient Welcome Packet. We look forward to seeing you!

PATIENT DEMOGRAPHICS

Patient Information		
Name:	Today's Date:	
Address:		
City:	State:	Zip Code:
Preferred Contact (Personal Phone, Work Phone, Mail, or Email):		
Preferred Phone Number (Personal, Work, or Other):		
Alternate Phone Number (Personal, Work, or Other):		
Email Address (to the extent that you would like us to potentially communicate with you by email):		
Date of Birth:	Social Security Number:	
Sex:	Ethnicity:	
Race:	Preferred Language:	
Marital Status (Circle One): Married, Single, Widowed, Divorced		
Do you live alone (Circle One): Yes, No If not, list who you live with:		
Religion:		
Highest Education Level (Circle One): College or Above, High School, Grade School		
Referring Physician (Name, Specialty, Office Name, Address, Phone Number):		
Primary Physician or Provider (If different than referring physician):		

Patient Employment	
Circle One: Employed, Retired, Unemployed, Other	
Employer's Name:	Occupation:

Emergency Contact(s)
List Name(s), Relationship(s), and Phone Number(s) for your emergency contact(s):

Responsible Party (If patient is under 18 years old)
List Name, Relationship to patient, Address, City/State/Zip, Phone Number, SSN, DOB for responsible party (if applicable):

Pharmacy Information	
Pharmacy Name:	Pharmacy Phone Number:
Pharmacy Address:	

Advanced Directives
Circle One: None, healthcare power of attorney, living will, healthcare proxy, DNR/DNI, guardian

Family History: (illness/condition)	Family Member						
Place an "X" in all appropriate boxes	Grandparents	Father	Mother	Brother	Sister	Son	Daughter
Heart attack							
Heart rhythm problem							
Congestive heart failure							
Heart valve problem							
High blood pressure							
Heart disease							
Diabetes							
Stroke or TIA							
Aneurysm							
High cholesterol							
Lung disease							
Kidney disease							
Blood clot							
Blood disorder							
Vascular or Arterial disease (Poor circulation in legs/feet)							
Cancer							
Alcohol/drug abuse							
Depression/psychiatric illness							
Genetic (inherited) disorder							
Autoimmune disease							
Other major illness?							

Review of Current Symptoms

Check the problems that you are currently experiencing or have experienced in the past 3 months [add boxes next to each]

GENERAL	**HEART**	**VASCULAR**	**MUSCLE/JOINTS**
Unintended weight gain Unintended weight loss Fever Fatigue Chills Other: Check box if NO to all: ☐	Chest pain Chest pressure Murmurs Fainting Palpitations Excessive sweating Other: Check box if NO to all: ☐	Claudication (leg pain) Edema (swelling) Foot or hand pain Foot or hand numbness Foot or hand tingling Other: Check box if NO to all: ☐	Joint pain Joint swelling Joint instability Stiffness Redness Heat Muscle pain Other: Check box if NO to all: ☐
EYES	**LUNGS**	**ENDOCRINE**	**NEUROLOGIC**
Vision changes Blurred vision Double vision Corrective lens Eye pain Eye redness Watering Other: Check box if NO to all: ☐	Shortness of breath Trouble breathing Snoring Coughing Wheezing Coughing blood Other: Check box if NO to all: ☐	Excessive thirst Heat/cold intolerance Excessive urination High blood sugar Goiter Tremors Other: Check box if NO to all: ☐	Dizziness Memory loss Tremors Unsteady gait Seizure Numbness/tingling Other: Check box if NO to all: ☐
EAR/NOSE/THROAT	**GASTRO**	**BLOOD**	**SKIN**
Headache Nose bleeds Ringing in ears Hearing loss Earache Difficulty swallowing Other: Check box if NO to all: ☐	Heart burn/reflux Nausea Vomiting Diarrhea Fecal incontinence Blood in feces Constipation Bloody/tarry stool Other: Check box if NO to all: ☐	Easy or more bleeding Bruising Blood clots Problems clotting Anemia Thrombocytopenia Other: Check box if NO to all: ☐	Redness Rash Itching Poor healing Pressure sores/ulcers Venous sores/ulcers Skin changes Other: Check box if NO to all: ☐

Medical History

Have you ever had the following? If yes, place an "X" under the currently column if you have it now, or place an "X" under the previously column if you do not have it currently.

Diagnosis/Condition/Problem	Current	History of?
Abdominal . Thoracic, Visceral Aneurysms or Aneurysm Repair		
Amputations		
Angioplasty		
Asthma		
Atrial fibrillation		
Bleeding disorder or problem		
Blood clots or Deep Vein Thrombosis		
Carotid disease		
Chronic wounds		
Coronary stent		
Diabetes		
Dialysis		
Emphysema		
Heart attack		
Heart disease		
High cholesterol		
Hypertension		
Kidney disease or insufficiency		
Neuropathy (decreased feeling in legs or feet)		
Pressure sores/ulcers		
Stroke or TIA		
Varicose veins		
Vascular/arterial disease or insufficiency - Claudication		
Vein stripping		
Venous sores/ulcers		

Preventative Care	
For each, please list the date the last time the test/examination was performed.	
ABI/TBI	Date:
Blood glucose	Date:
Foot exam	Date:
Arterial/venous ultrasound	Date:
HgBA1c %	Date:

Surgical History			
Please list every surgery or procedure that you've had performed			
Surgery/procedure	Why performed?	Who performed?	When performed?

Recent Hospitalizations		
Please list every time that you've been hospitalized		
When hospitalized?	Why hospitalized?	Where hospitalized?

Current Medications		
Please list all prescription, non-prescription, vitamins, and nutritional supplements that you currently take.		
Current Medication	Dose (strength)	Dosage (how many and times per day)
Example: Lopressor	50 mg	1 tablet, 2 times a day

In the past two years, have you stopped taking any prescription medications? If so, please name the prescription medication, your dosage, when you stopped taking it, and why you stopped taking it. _____

Allergies or Adverse Drug Reactions	
Please list all of your allergies, including food allergies and drug-related allergies	
Allergy	Reaction

PATIENT AGREEMENTS
Acknowledgement of Medical Issue Review

Additional Information:

Is there anything else that you would like your provider to know about you or your health, or that your provider should otherwise be aware of to provide you with appropriate medical care?

_____

Acknowledgement and Attestation:

I acknowledge that I reviewed the New Patient Packet, which includes all the forms and agreements listed above on page 2. I also certify that I read and understand SLVSS' expectations of me as a patient and accept the same as terms of receiving treatment at SLVSS. I have had had the opportunity to review in person the packet and ask questions.

I attest that the information I have given above is full, correct, and true to the best of my knowledge. I understand and acknowledge that providing a full, correct, and true medical history is essential for SVSS to provide me with appropriate treatment.

Patient Name:_____

Patient Signature:_____

Date:_____

General Consent for Treatment

As a patient, you have the right to be informed about your condition(s) and the recommended surgical, medical, or diagnostic testing or treatment, including the risks and hazards involved, so that you may make an informed decision whether to undergo the suggested testing or treatment(s). At this point in your care, no specific treatment plan has been recommended. By signing this agreement, you provide your consent to perform the evaluation necessary to identify appropriate treatment(s) and/or procedure(s) for any identified condition(s).

This agreement also provides us with your general permission to perform any and all reasonable and medically necessary examinations, testing, and treatments that you agree to in your discretion. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and specific treatment recommended. Your consent will remain fully effective until it is revoked in writing and will therefore apply to each visit that you have with any of our providers, including for any future medical care or treatment which may be needed but which is not known at the time that you sign this agreement. You may at any time choose to discontinue our services or revoke this consent by written notice to us.

You have the right to discuss any aspect of your treatment plan with your physician or other appropriate provider(s), including the purpose and potential risks and benefits of any treatment(s) or test(s) ordered for you. If you have any concerns or confusion regarding any test or treatment recommended by your physician or other appropriate provider, we encourage and expect you to ask questions. Please also see your New Patient Intake Package for self-education resources, which we also encourage and expect you to utilize.

In consideration of receiving treatment from St. Louis Vascular Surgical Specialists, PC ("SVSS") and its providers, I affirmatively state or otherwise agree to the following:

A. I have and will continue to provide truthful, accurate, and complete information regarding my health and medical history, and I understand and acknowledge that SVSS and its physicians and providers will rely upon such information in determining and recommending medical treatment(s) to me. I take responsibility for any adverse outcome for failing to do so.

B. I authorize and consent to assessment, care, examination, and treatment (including, without limitation, any medications, laboratory tests, imaging studies, diagnostic or other procedures, services, and supplies) as SVSS, its physicians and other providers, may determine in their judgment to be necessary, appropriate, or desirable for me. I understand that if additional testing or procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

C. I understand that it is not possible to list each and every risk for every type of health care service which may occur in relation with my medical treatment and that there may be material risks associated with medical treatments that will be provided to me.

D. I understand that the practice of medicine is not a perfect science, and that every test, treatment, surgery, or other procedure carries inherent risks, including without limitation unsuccessful results, complications, and/or injuries, from both known and unforeseen causes. I acknowledge that fact and certify that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** or otherwise implied regarding the results of my medical treatment(s) or cure of my medical condition(s).

E. I understand and acknowledge that receiving medical treatment does **NOT** ensure healing or otherwise prevent my medical condition(s) from getting worse.

F. I understand my responsibilities as SVSS' patient that are reflected in my New Patient Intake Package.

G. I understand that there are many variables and circumstances out of SVSS' control that can negatively affect my health or worsen my medical condition(s), including, without limitation, my lifestyle choices, medications, infections, age, deformities, circulation issues, diabetes, edema, mental cognition or communication, mental health, and general drive to get better.

H. <u>If I am a patient with chronic wounds</u>, I understand that there are additional variables or circumstances out of SVSS' control that can prevent my wounds from healing or otherwise that can make my wounds get worse, including without limitation the location of my wounds, my activity level, my ability to move or reposition myself, incontinence problems, pressure problems, cleanliness, blood thinning medications, and bleeding or clotting problems.

I. I understand and acknowledge that things may not go as intended in my treatment plan. If I have an adverse and/or unexpected result, I understand that fact does not mean that SVSS or any of its providers did anything wrong.

I certify that I have read and fully understand the above General Consent for Treatment, that I adopt any statements attributed to me as my own statements, and that I fully and voluntarily agree and consent to the same.

Patient Name:_____

Patient Signature:_____

Date:_____

Financial Agreement and Authorization

For purposes of this agreement, "Insurance" means any policy, plan, product, network, employer benefit or plan, self-insured program, or government program or assistance applicable to me.

I understand that I am financially responsible for and obligated to pay all charges by St. Louis Vascular Surgical Specialists, PC ("SVSS") in connection with my medical treatment. I understand that SVSS may perform medically necessary services as well as elective services, which I have the right to consider or decline before those services are rendered. My consent to undergo such treatment and/or services evidences my agreement to pay for them.

At the time services for my care are rendered, I will pay any copayment, deductible, or coinsurance, if applicable, and will otherwise pay the amount for any services that are not covered by Insurance. If my Insurance plan requires an authorization or referral before I receive services from SVSS, I must obtain it prior to my visit. I understand that I am personally responsible for the costs of services rendered if I fail to comply with the terms of my Insurance plan or agreement.

I authorize and direct payments of my medical benefits under my Insurance to SVSS on my behalf for any services furnished to me by its physicians and providers. I agree to use my best, good faith efforts to cooperate with and assist SVSS in receiving payment in full for the services rendered to me, including, without limitation, by remitting to SVSS any payments I receive from an insurer or from any other source whatsoever relating to the care provided to me by SVSS, its physicians and providers.

In the event that my Insurance determines that a provided medical service is not covered by my plan, I will be responsible to SVSS for the complete charge and agree to pay the costs of all such services rendered.

I hereby authorize SVSS to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care all information or documentation necessary or otherwise requested to substantiate or facilitate payment for such medical care, including, without limitation, information or documentation regarding my diagnoses or records reflecting the treatments or examinations rendered to me. I further authorize SVSS to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care any information required for precertification, authorization, or referral to another medical provider.

I understand that I have the option to pay for a health care service personally without submitting a claim to Insurance, however, if I elect this option, I must notify SVSS, reach mutually agreeable terms for the same, and thereafter must pay SVSS for that health care service in full at the time that the service is rendered.

If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

Unless otherwise agreed to in writing, whether I have Insurance or not, payment of my account balance is due within thirty (30) days of receipt of my billing statement. If my account is over sixty (60) days past due, my account will be in default and may be referred to a collection agency or an attorney, which may potentially result in judicial or nonjudicial action. I acknowledge that if my

account is referred to a collection agency or attorney and later to a credit reporting agency, it may have an adverse effect on my credit history.

If I am in default of my account with SVSS, I authorize SVSS to disclose to any outside collection agency or attorney all relevant personal and account information necessary to collect payment for the services rendered to me. If my account is referred to a collection agency or attorney, I am responsible for a $100.00 administrative default fee.

Once in default, interest on the principal balance of my account will begin to accrue at the highest applicable rate permitted by law.

I understand that I can make payments by check, money order, debit card, or credit card. However, if any of my payments fail for any reason, I am responsible to pay SVSS a surcharge of $50.00 for each failed payment, any costs or fees incurred by SVSS, and any other costs or fees assessed or charged to SVSS by the third-party company that handled my payment (3.5% for all Credit Card transactions).

By using a credit or debit card for any payment of any invoice or balance, I expressly represent that I am an authorized user of that card and that I authorize SVSS to charge the card for the total amount listed in the invoice or balance, unless otherwise indicated. If I use a credit or debit card to make any payment, and if the card that I used changes or expires, or if the payment is denied, rescinded, or refunded for any reason, I agree to immediately give SVSS a new, valid card, agree that SVSS may charge the new card over the phone, and agree that my previous authorization provides authorization to charge my new card. Alternatively, I can pay the failed payment amount using another allowable payment medium described above.

By using a credit or debit card, I also certify that I will not dispute the payment with my credit card company or bank, whichever is applicable, so long as the transaction corresponds to the terms of this Agreement and accurately relates to services provided to me by SVSS. I further agree that I am personally responsible to pay SVSS for any cost, fee, or any other expense that SVSS incurs as a result of my credit card company or bank failing to make any payment on my behalf, whether at my direction or not.

To the extent that I use a credit or debit card to make any payment and for any reason that payment is later disputed or cancelled, resulting in a non-payment to SVSS, I hereby expressly authorize SVSS to provide to my credit card company or bank, whichever is applicable, and subject to any applicable laws, and outside of any legal recourse that may also be available to SVSS, any information or documentation that evidences the medical care or treatment that it provided to me, including, without limitation, my personal health information, my medical records, my billing records, and other relevant agreements.

I am responsible for all costs and expenses incurred by SVSS in connection with any "chargebacks" or "refunds" if (1) I use a credit or debit card to make a payment, (2) I later dispute the payment, or my legal representative or another authorized card user disputes the payment, (3) the dispute results in the credit card company or bank rescinding or cancelling the payment to SLVSS, resulting in a "chargeback" or a "refund" to the benefit of the card holder(s), (4) I refuse

to pay SVSS for the full amount of the initial payment for whatever reason(s) for at least two weeks following SVSS' demand for a new payment, whether made orally or in writing, (5) because of my continued refusal to make the full payment, SVSS is forced to resolve the dispute with my credit card company or bank, or through a legal process, and (6) my credit card company or bank, or a court, or an arbitration panel, whichever is applicable, determines that SVSS' initial invoice or charge was accurate based on the medical care provided to me, including (a) any applicable late fees or charges described above, (b) $250.00 in additional liquidated damages, (c) interest accruing at the maximum allowable rate under Missouri law from the date that the initial payment was disputed to the date of final resolution, (d) SVSS' attorneys fees, (e) any court or arbitration costs, and (f) any other reasonable expenses incurred during the process.

If SVSS takes any action against me to enforce its right to payment for services rendered, whether through a collection agency or through an attorney, in addition to the principal balance and any other charges or fees already accrued, I am responsible for all costs and expenses associated with SVSS' collection efforts, including without limitation late fees, interest on my account balance, administrative charges, attorneys' fees (if SVSS is successful in a legal proceeding), and court and/or arbitration costs (if applicable). Furthermore, if any court or arbitration panel enters a final judgment or decision in favor of SVSS and against me, I agree to pay to SVSS any and all interest accruing at the maximum amount allowed under Missouri law that accrues from the date that judgment or decision is entered to when I pay off my entire account balance.

I understand that I am ultimately responsible for payment for the services that I receive at SVSS. I have had the opportunity to read this Financial Agreement and Authorization in its entirety and have had the opportunity to ask questions regarding its details. Any questions have been answered to my satisfaction. I consent and agree to the terms of the Financial Agreement and Authorization.

Patient Name:_____

Patient Signature:_____

Date:_____

Insurance and Authorization Assignment

Please read and sign:

I attest that the information I have given here is correct and true to the best of my knowledge. I authorize and hereby assign my insurance benefits to be paid directly to Dr. Robert Hacker and authorize him and St. Louis Vascular Surgical Specialists, PC (SVSS) to furnish any information regarding my health and medical care to my insurance carrier to process my claims, as further described in the Financial Agreement and Authorization. I understand that I am responsible for any amount not paid for by my insurance. I further authorize St. Louis Vascular Surgical Specialists to obtain medication history electronically from my pharmacy benefit administrator.

Patient Name:_____

Patient Signature:_____

Date:_____

ST. LOUIS VASCULAR SURGICAL SPECIALISTS, PC

NOTICE OF PRIVACY PRACTICES

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 questions about this notice or want more information, please contact: Jan Boring, Privacy Officer at 314-755-1184. The effective date of this notice is 8/1/2023.

To appropriately treat you and receive payment for the services we provide, we need to obtain information from you including your full name and address, insurance company, family medical history, current medical history, and current medical condition. We will use and disclose this information and other information we collect in the ways described below. To help you understand how we will use and disclose your information we have put the different uses and disclosures into categories and give examples of each. All of the ways we use or disclose your information will fit into one of the categories listed below, but we cannot list all of the uses and discloses in each category.

We may use and disclose your health information for treatment, payment, and health care operations.

- **Treatment**. We may use and disclose your information to provide you with medical treatment and services. Your information may be disclosed to individuals and facilities providing care to you. These individuals and facilities need your information to provide care, and to coordinate and provide services (such as prescriptions, lab tests, and x-rays).
- **Payment**. We may use and disclose your information to receive payment for the services and treatment provided to you. We use your information to create a bill and disclose your information when we send the bill to your insurance company, you, or a third party. The individual or entity paying the bill may request more information to determine whether the bill is covered by your insurance. We may tell your health plan about a treatment you are going to receive to get approval for payment or to determine whether your health plan will cover the treatment.
- **Health Care Operations**. We may use and disclose your information for health care operation purposes. Health care operations includes review of the care you receive for quality assessment, educational, business planning, and compliance plan purposes.
- **Appointment Reminders**. We may provide appointment reminders to you. You may request in writing that we send reminders to a confidential or alternative address.

- **Treatment Alternatives**. We may provide you with information about treatment alternatives and other health related benefits and services.
- **Business Associates.** We may provide your information to people or companies who are performing the above services on our behalf as our business associates. Our business associates sign written agreements to only use or disclose your information consistent with this notice.

We may also disclose your health information to outside entities without your consent or authorization in the following circumstances:

- **Required by Law**. We disclose information as required by law. For example, we are required to report gunshot wounds to the police. We are also required to provide information to the Secretary of the Department of Health and Human Services to demonstrate our compliance with HIPAA.
- **Public Health Purposes**. We disclose information to health agencies as required by law for preventing or controlling disease. Examples are reporting of sexually transmitted, communicable, and infectious diseases.
- **To Prevent a Serious Threat to Health or Safety**. We may disclose information about you to law enforcement or an identified victim to prevent a serious threat to your health or safety or the health or safety of another individual or the public.
- **Research**. Your information may be used by or disclosed to researchers for research approved by a privacy board or an institutional review board.
- **Health Oversight Activities**. Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.
- **Judicial and Administrative Proceedings**. We may be required to disclose your health information to a court or for an administrative proceeding.
- **Law Enforcement Activities**. We may be required to disclose your information as required by law, pursuant to a court order, warrant, subpoena, or summons.
- **Deceased Individual**. We may disclose information for the identification of the body or to determine the cause of death.
- **Military and Veterans**. If you are a member of the armed forces we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official. This release must be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety or security of the correctional institution.
- **Organ and Tissue Donation**. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ or tissue donation.

- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs.
- **Specialized Governmental Functions**. We may release information about you to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We will give you the opportunity to object to the following uses and disclosure of your information:

- **Individuals Involved in Care**. We may tell your friends, relatives and other caretakers information which is relevant to their involvement in your care.
- **Disaster Relief**. We may disclose information about you to public or private agencies for disaster relief purposes.

Except as provided above, we will obtain your written authorization prior to disclosure of your information for any other purpose. Specifically, written authorization is required prior to the disclosure of your information:

- **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without a written authorization except as specifically permitted by law.
- **Marketing**. We will not use or disclose your information for marketing purposes, other than face-to-face communications with you or promotional gifts of nominal value, without your written authorization.
- **Sale of Information**. We will not sell your PHI without your written authorization, including notification of the payment we will receive.

Where a disclosure is made under your written authorization, you have the right to revoke the authorization at any time. Revocation of an authorization must be in writing. The revocation is effective as of the date you provide it to us and does not affect any prior disclosures made under the authorization.

If a state or federal law provides additional restrictions or protections to your information, we will comply with the most stringent requirement.

Your Rights

- You have the right to request a restriction on how information about you is used and disclosed. If you want to request a restriction of a use or disclosure of your information, contact our Privacy Officer at the number listed at the beginning of this form. We are required to agree to a request for a restriction related to disclosure of information to your health plan for payment or healthcare operations where you pay for the service in full. **We are not otherwise required to agree to any restriction on the use or disclosure of your information.**

- You have the right to request communications with you be made at an alternative address or phone number. To request that communication be made at a different address or phone number contact our Privacy Officer at the number listed at the beginning of this form to obtain the form to make your request.
- You have the right to inspect and copy your medical record. To inspect and copy your medical record a request must be made in writing. To access your record, contact our Privacy Officer at the number listed at the beginning of this form.
- If you believe the information we have about you is incorrect or incomplete you may request that we amend your medical record. Your request must be made in writing. To request an amendment, contact our Privacy Officer at the number listed at the beginning of this form.
- You have the right to receive an accounting of disclosures, a list of individuals and entities that received your health information for reasons other than treatment, payment, or healthcare operations. You may receive one (1) free accounting during a twelve (12) month period. If you request more than one (1) accounting in a twelve (12) month period, you will be charged a fee. An accounting is not provided for disclosures prior to April 14, 2003.
- You have the right to request a paper copy of this Notice.

Our Duties

- We are required by law to maintain the privacy of PHI and to provide individuals with this Notice of our legal duties and privacy practice regarding health information.
- We are required to notify you if there is a breach of your unsecured PHI.
- We are required to follow the terms of the current Notice.
- We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted and a copy may be requested from our Privacy Officer at the number listed at the beginning of this form.

Complaints

If you believe your privacy rights have been violated you may contact:

Jan Boring, Privacy Officer at 314-755-1184 or the Office of Civil Rights. You will not be penalized for filing a complaint.

PRIVACY PRACTICES - HIPAA

Name _____ Date of Birth _____

ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

I have been provided with or offered a copy of the Notice of Privacy Practices of St. Louis Vascular Surgical Specialists, PC. I acknowledge that this Notice of Privacy Practices may be revised by St. Louis Vascular Surgical Specialists, PC at any time and that I may request a copy of the current Notice from the practice.

_____ _____

Signature Date

INDIVIDUALS INVOLVED IN MY CARE

I authorize **St. Louis Vascular Surgical Specialists, PC** to disclose my Protected Health Information to the following individuals involved in my care for the purpose of facilitating their involvement.

Name Relationship Description of Involvement/Information to be Disclosed

_____

_____

_____

_____

- I understand that I may notify the practice of any changes to the individuals involved in my care at any time and that the authorization to share information described above will continue until I notify the practice of changes.
- I understand that this authorization is voluntary and I am not required to designate any individuals in order to receive services from the practice.
- I understand that I may revoke this authorization at any time. I understand that my revocation will have no effect on any actions taken pursuant to this authorization prior to the revocation.
- I understand that the information disclosed pursuant to this authorization may be further disclosed by the recipient and may no longer be protected under HIPAA.

_____ _____

Signature Date

_____ _____

If Personal Representative, Printed Name Relationship to Individual

Notice of Possible Exposure to Radiation

Ionizing Radiation is Used for SOME procedures in this building. The unit is registered with the state and dosimetry is regularly measured for your safety.

If you or any family members think that they are pregnant or could be pregnant, please let SVSS staff know immediately or leave the area when radiation is being used. Failure to do so can result in:

Birth defects, tumors, cancer, cataracts, skin burns, hair loss and other ailments.

Should you have any questions please ask Dr. Hacker or other staff immediately.