**BERKS CARDIOLOGISTS, LTD.**

Dear Patient,

Welcome to Berks Cardiologists. We look forward to serving your needs, and will do everything possible to make your visit a pleasant one.

Your first scheduled appointment will be at our Spring Ridge medical office which is located at **2605 Keiser Blvd, Wyomissing, PA.**

- **Custom driving directions.** Browse to our Web site at www.berkscardiologists.com, click to *Enter Site*, and click on *Map & Directions*. Please be sure to arrive on time for your appointment since a special time is reserved just for you, and it is important that all patients are seen on a timely basis.

- **Bring all of your present medications with you**. This is very important. (Please bring either the medicine bottle, or a current list with the name of the medicine and dosage.) If you have had any cardiac testing or blood work done through you family doctor, please have your family doctor forward copies to us.

- **Please enter all the information requested on pages 2 through 9**. The remaining unnumbered pages titled "HIPAA NOTICE OF PRIVACY PRACTICES are to be retained for your records.

- **Please bring the completed forms** with you, along with **your insurance identification cards** and **any other information that may help us process your registration**.

- **If you have any questions** about completing the forms, **please call** the Spring Ridge office at **610-685-8500.**

- *If your insurance requires a referral from your primary care physician*, please be sure to **bring the referral form with you**. Please note it is your responsibility to obtain the referral form. Completion of the enclosed forms prior to your visit along with any required referral will help us to see all of our patients on a timely basis.

- **It is our policy to expect payment for services rendered at the time of the visit**. Please be prepared to pay for any services not covered by your insurance. For your convenience, cash, personal checks, money orders, VISA and/or MasterCard are accepted. If you have any questions regarding your billing, please contact the Financial Counselor, Roberta Ferry at 610-685-4879 extension 208.

Again, we look forward to seeing you, and making your visit as enjoyable as possible. Please do not hesitate to call if you have any questions. A toll free number is provided for your convenience of out of area callers 1-800-553-6631.

Sincerely,

Valerie J. DeVine
Chief Operating Officer

# Berks Cardiologists, Ltd.

## MEDICAL HISTORY

Name: _____ Date:_____ Age:_____

Reason for visit: _____

Other:_____

### HISTORY OF PRESENT ILLNESS
### CURRENT SYMPTOMS

Are you having any of these current symptoms?

| | Yes | How long | | Yes | How long |
|---|---|---|---|---|---|
| Chest pain | ☐ | _____ | Palpitations | ☐ | _____ |
| Short of Breath | ☐ | _____ | Fainting/Pass out | ☐ | Last incident: _____ |
| Dizziness | ☐ | _____ | | | |

If having **chest pain:**

Last incident: _____ How long did it last?:_____

Was it relieved with medication? Yes No

If yes, what medication did you take? _____

Does pain: Go into neck or arms? Yes No

Occur with rest? Yes No

Occur with exercise? Yes No

### REVIEW OF SYMPTOMS

(Check appropriate symptoms)

**1. General:**
- ☐ Fevers
- ☐ Chills
- ☐ Significant weight gain
- ☐ Fatigue

**2. ENT:**
- ☐ Difficulty hearing
- ☐ Vertigo
- ☐ Snoring
- ☐ Nose bleeds

**3. Respiratory:**
- ☐ Cough
- ☐ Blood in sputum
- ☐ Short of breath
- ☐ Wheezing

**4. G.I.**
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool

**5. GU:**
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Pain while urinating

**6. Musculoskeletal:**
- ☐ Arthritis
- ☐ Pain in joints
- ☐ Swollen joints

**7. Neuro:**
- ☐ Loss of consciousness
- ☐ Dizziness
- ☐ Slurred speech
- ☐ Seizures
- ☐ Tremors

## PAST MEDICAL HISTORY

(Please check yes or no)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Abdominal Aortic Aneurysm | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Atrial Fibrillation | ☐ | ☐ | Heart Murmurs | ☐ | ☐ |
| Anemia | ☐ | ☐ | High Cholesterol | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Hypertension or elevated blood pressure | ☐ | ☐ |
| Cancer | ☐ | ☐ | | | |
| Congestive Heart Failure | ☐ | ☐ | Reflux Disease | ☐ | ☐ |
| COPD/Asthma | ☐ | ☐ | Thyroid Disorder | ☐ | ☐ |
| Coronary Artery Disease/ Heart Attack | ☐ | ☐ | Valvular Heart Disease | ☐ | ☐ |
| | | | Other:_____ | | |

## PAST SURGICAL HISTORY

| | Yes | Year | | Yes | Year |
|---|---|---|---|---|---|
| 1. Appendix | ☐ | ____ | 7. Heart Bypass Surgery | ☐ | ____ |
| 2. Cataract | ☐ | ____ | 8. Valve Replacement | ☐ | ____ |
| 3. Gall Bladder | ☐ | ____ | 9. Pacer/Defibrillator | ☐ | ____ |
| 4. Hysterectomy | ☐ | ____ | 10. Carotid Endarterectomy | ☐ | ____ |
| 5. Prostate | ☐ | ____ | 11. Aneurysm Repair | ☐ | ____ |
| 6. Tonsillectomy | ☐ | ____ | 12. Peripheral Arterial Bypass | ☐ | ____ |

Other: _____

## SOCIAL HISTORY

1. **Smoking:** Currently smoke ☐ How many per day? _____ Never smoked ☐

   Past smoker ☐ When did you quit?_____ How many years did you smoke? _____

2. **Alcohol:** Socially ☐ Moderately ☐ Regularly ☐ Never ☐

3. **Marital Status:** Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐

4. **Occupation:** _____

5. **Residence:** Live alone ☐ Live with spouse/companion ☐ Live with family ☐

   Other: _____

## FAMILY HISTORY

| | | Heart Disease | Deceased (yes or no) |
|---|---|---|---|
| 1. **Family Heart Disease:** | Mother | _____ | _____ |
| | Father | _____ | _____ |
| | Sister | _____ | _____ |
| | Brother | _____ | _____ |

## MEDICATIONS

(Please list with dosages)

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

| | Yes | No | |
|---|---|---|---|
| Drug Allergies: | ☐ | ☐ | If yes, list medications: _____ |
| Dye Allergy | ☐ | ☐ | _____ |
| Shellfish Allergy | ☐ | ☐ | _____ |

| Test History | Date | Hospital or other location where test was done |
|---|---|---|
| EKG | _____ | _____ |
| Echocardiogram | _____ | _____ |
| Stress Test | _____ | _____ |
| Holter Monitor | _____ | _____ |
| Lab Tests | _____ | _____ |
| Other Tests | _____ | _____ |

## HOSPITALIZATION FOR HEART

| | Hospital | Doctor | Year |
|---|---|---|---|
| Heart Catheterization | _____ | _____ | _____ |
| PTCA (Balloon Angioplasty) | _____ | _____ | _____ |
| Bypass Surgery | _____ | _____ | _____ |
| Other | _____ | _____ | _____ |

## RECENT HOSPITALIZATIONS (Other than previous section)

| | | | |
|---|---|---|---|
| St. Joseph Medical Center | Yes | No | Reason: _____ |
| Reading Hospital | Yes | No | Reason: _____ |
| Other | Yes | No | Reason: _____ |

**BERKS CARDIOLOGISTS, LTD.**

**PATIENT INFORMATION**

Mr.☐ Mrs.☐ Ms.☐ : _____ __ _____
First Middle Initial Last

Street Address: _____

City:_____ State:_____ Zip Code:_____

Tel #:_____ Sex:____ SS#: ____ ___ _____ Date of Birth:_____
M/F ### ## ####

Check one: Single☐ Married☐ Divorced☐ Widow/Widower☐ Other:_____

Check one: Employed☐ Retired☐ Disabled☐ Other:_____

If employed, name of employer: _____

Family MD: _____ Referring MD: _____

Address: _____ Address: _____

If a minor, parent's name: _____ SS #:____ ___ _____ Date of Birth:_____
### ## ####

---

Spouse's name:_____ Spouse's Date of Birth:_____

Spouse's SS #:____ ___ _____ Spouse is (check one): Employed☑ Retired☐ Disabled☐
### ## ####
Other: _____

If employed, Employer's name:_____ Do they provide insurance coverage: _____
Y/N

If not employed, date last worked:_____

---

Please list the individuals (such as spouse, family member or close friend) involved in your care and/or payment for your care to whom we may disclose your health information to the extent necessary to help you with your health care or with payment for your health care:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

## INSURANCE INFORMATION

**Insurance No. 1** (health insurance through patient's employer or Medicare if eligible)

Insurance Co : _____ Identification #: _____

Group #: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ _____ ____ _____
Street City State Zip

Employer's Phone #: _____ Currently working: Yes No
Please let us know if pre-certification is a requirement with your insurance company. _____

**Insurance No. 2** (health insurance through spouse or other family member's employer or supplemental)

Insured's Name: _____ Relationship to Patient: _____

Insurance Co : _____ Identification #: _____

Group #: _____ Date of Birth: _____

Social Security #: ____ ___ _____ Employer Name: _____
### ## ####

Occupation: _____ Employer's Phone #: _____

Employer Address: _____ _____ _____ _____
Street City State Zip

Is the insured (check one): ☐ Employed ☐ Retired (Date)_____ Currently working: Yes No

Is any portion of this bill to be covered by:
Auto Insurance ☐ Black Lung ☐ Workman's Comp. ☐ VA ☐

Insurance Co : _____ Identification #: _____

Group #: _____ Date of Birth: _____

Social Security #: ____ ___ _____ Employer Name: _____
### ## ####

Occupation: _____ Employer's Phone #: _____

THE ABOVE SPACE CAN BE USED FOR A THIRD INSURANCE OR AUTO, WC ETC

THANK YOU FOR YOUR PATIENCE IN FILLING OUT THIS FORM AND HELPING US TO SERVE YOU BETTER.

BERKS CARDIOLOGISTS, LTD.
2605 KEISER BOULEVARD
WYOMISSING, PENNSYLVANIA 19610

*ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT*

I hereby direct and instruct the following insurance carriers to pay directly to Berks Cardiologists, Ltd. the professional or medical expense benefits allowable and otherwise payable to me under my current policies as payment toward the total charges for professional services rendered by Berks Cardiologists, Ltd.:

Primary Insurer: _____ Policy/ID # _____

Secondary Insurer: _____ Policy/ID # _____

Supplementary Carrier: _____ Policy/ID # _____

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THESE POLICIES.** If any of these insurance policies prohibits direct payment to Berks Cardiologists, Ltd., then I hereby direct and instruct the above-named insurance carriers to name myself and Berks Cardiologists, Ltd. as payees on all checks and to mail such checks as follows:

C/o BERKS CARDIOLOGISTS, LTD.
2605 Keiser Boulevard
Wyomissing, PA 19610

I understand that my insurance carriers may not cover the charges for some of the services rendered to me by Berks Cardiologists, Ltd., or may cover certain charges in part but not in full. I also understand that, except where Berks Cardiologists, Ltd. is required by law or governmental regulation to accept the amount paid by my insurance carriers as payment in full, I am responsible for the payment to Berks Cardiologists, Ltd. of any charges not paid in full by my insurance carriers and I agree that I will pay any charges not paid in full by them within (90) days of the date the services were rendered.

I hereby, make, constitute and appoint Berks Cardiologists, Ltd. and any of its duly designated agents or employees to be my true and lawful attorney with respect to checks, drafts, and/or money orders payable to Berks Cardiologists, Ltd., for services rendered to me. By this power, I further give and grant to Berks Cardiologists, Ltd., full power and authority to endorse on my behalf and to cash checks received from insurance carriers for services rendered it has to me by Berks Cardiologists, Ltd. Finally, I authorize Berks Cardiologists, Ltd. to release to my insurance carriers any information and records relating to any examination, tests, diagnosis, treatment or other services rendered to me by or on behalf of Berks Cardiologists, Ltd.

**A PHOTOCOPY OF THIS ASSIGNMENT AS SIGNED BY ME SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.**

_____ _____
Date Patient's full name (Please print)

_____ .....
Account No. Patient's Signature

**Berks Cardiologists, Ltd.**

**Acknowledgement of Receipt of Notice of Privacy Practices**

*I acknowledge that I received the Notice of Privacy Practices for Berks Cardiologists, Ltd.*

_____
Patient's Name (please print)

..... _____
Signature of Patient Date of Receipt

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FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Patient refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify _____

_____

---------- ----------
Staff Signature Date

***HIPAA NOTICE OF PRIVACY PRACTICES***

**Berks Cardiologists, Ltd.**

**Effective Date: April 14, 2003**

## THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

## PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact Valerie J. DeVine, Chief Operating Officer at (610) 685-4879.

### OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health Information about you; and
- follow the terms of the notice that is currently in effect

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment.** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. Some examples of treatment uses and disclosures include:

- during an office visit, physicians and other staff involved in your care may review your medical record and share and discuss your medical information with each other
- we may share and discuss your medical information with an outside physician to whom we have referred you for care
- we may share and discuss your medical information with an outside laboratory, radiology center, or other health care facility where we have referred you for testing
- we may share and disclose your medical information with an outside home health agency, durable medical equipment agency or other health care provider to whom we have referred you for health care services and products
- we may share and discuss your medical information with another health care provider who seeks this information for the purpose of treating you
- we may use a patient sign-in sheet in the waiting area which is accessible to all patients
- we may page patients in the waiting room when it is time for them to go to an examining room and/or testing area
- we may contact you to provide appointment reminders
- we may contact you to provide lab and test results and other information necessary for your health care treatment and services

**For Payment:** We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or third party. Some examples of payment uses and disclosures include:

- sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service
- submission of a claim form to your health insurer
- providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement
- sharing your demographic information (for example, your address) with other health care providers who seek this information to obtain payment for health care services provided to you
- mailing your bills in envelopes with our practice name and return address
- provision of a bill to a family member or other person designated as responsible for payment of services rendered to you
- providing medical records and other documentation to your health insurer to support the medical necessity of a health service
- allowing your health insurer access to your medical record for a medical necessity or quality review audit
- providing consumer reporting agencies with credit information (your name and address, date of birth, social security number, payment history, account number and our name and address)
- providing information to a collection agency or our attorney for purposes of securing payment of a delinquent account
- disclosing information in a legal action for purposes of securing payment of a delinquent account

**For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

**Appointment Reminders/Lab and Test Results:** We may use and disclose health information to provide you and/or individuals involved in your care or payment for care with appointment reminders and to provide lab and test results (such as telephone calls, voicemail messages, postcards or letters). Please let us know if you do not wish to have us contact you concerning your appointment and/or lab or test results, or if you wish to have us use a different telephone number or address to contact you for this purpose.

**Research.** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process; but we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

**As Required By Law.** We will disclose health information about you when required to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Military and Veterans.** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

**Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify person or organization required to receive information of FDA-regulated products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release health information if asked to do so by a law enforcement official:

- in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person:
    - Name and address
    - Date of birth or place of birth;
    - Social security number;
    - Blood type or rh factor;
    - Type of injury;
    - Date and time of treatment and/or death, if applicable; and
    - A description of distinguishing physical characteristics.
- about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;

- about a death we believe may be the result of criminal conduct;
- about criminal conduct at our facility; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

**Individuals Involved in Care or Payment for Care.** We may disclose your health information to someone involved in your care or payment for care, such as a spouse, family member or close friend to the extent necessary to help with your health care or with payment for your health care.

**Coroners, Health Examiners and Funeral Directors.** We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would 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 and security of the correctional institution.

**Business Associates.** Certain functions of the practice are performed by a business associate, including but not limited to, a billing company, an accountant firm, or a law firm. We may disclose protected health information to our business associates and allow them to create and receive protected health information on our behalf.

**Incidental Disclosures.** We may disclose protected health information as a by-product of an otherwise permitted use or disclosure. For example, other patients may overhear your name being paged in the waiting room.

**Notification Purposes.** We may use and disclose your protected health information to notify or to assist in the notification of a family member or personal representative, or another person responsible for your care, regarding your location, general condition or death.

**Uses and Disclosures with Authorization.** For all other purposes that do not fall under a category listed above, we will obtain your written authorization to use or disclose your protected health information. Your authorization can be revoked at any time except to the extent that we have relied on the information.

**YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.**

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy:** You have the right to inspect and copy health information they may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Valerie J. DeVine, Chief Operating Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice

will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to Valerie J. DeVine, Chief Operating Officer, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

**Right to an Accounting of Disclosures.** You have the right to request a list of accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to Valerie J. DeVine, Chief Operating Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

**We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide to you.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Valerie J. DeVine, Chief Operating Officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to Valerie J. DeVine, Chief Operating Officer. We will not ask the reason for your request. We are not required to agree to requests for confidential communications that are unreasonable. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from Valerie J. DeVine, Chief Operating Officer.

You may also request a copy of this notice be sent through electronic mail to vdevine@berkscardiologists.com. If we know that the electronic message has failed to be delivered, a paper copy of the notice will be provided. Even if you have received a notice electronically, you still retain the right to receive a paper copy upon request.

**If the first service delivery is delivered electronically, other than by telephone, we provide electronic notice in the same medium, automatically and contemporaneously in response to a first request for service.**

## CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Valerie J. DeVine, Chief Operating Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

## OTHER USES OF HEALTH INFORMATION.

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

## LEGAL EFFECT OF THIS NOTICE

This notice is not intended to create contractual or other rights independent of those created in the federal privacy rule.

## Acknowledgement of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.

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