



# MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD.

## PATIENT INFORMATION

Name: \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Marital Status: [ ] Married [ ] Single [ ] Separated/Divorced Sex: [ ] M [ ] F  
Referring Physician: \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_

### INSURANCE

Primary Insurance Carrier \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_  
Policy Holder's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Secondary Insurance Carrier \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_  
Policy Holder's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### EMPLOYMENT INFORMATION

Employer \_\_\_\_\_  
Employer Phone \_\_\_\_\_

### CONTACTS

1 Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_  
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_



# MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD.

## PATIENT MEDICAL INFORMATION

Name \_\_\_\_\_

Married \_\_\_ Single \_\_\_ Separated/Divorced \_\_\_ Occupation \_\_\_\_\_

### HOSPITALIZATIONS

If you have ever been hospitalized, please list the approximate date and reason (i.e. surgeries)

	<u>Date</u>	<u>Reason</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

### MEDICATIONS

Please list all medications you are currently taking.

	<u>Name of Medicine</u>	<u>Dosage</u>	<u>When Taken</u>	<u>Prescribing Physician</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

### ALLERGIES

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If you have a Living Will, please provide Mid-Atlantic Cardiothoracic Surgeons, Ltd. and your primary care physician with a copy for your medical records.

JEFFREY B. RICH, M.D.  
JOSEPH R. NEWTON, JR., M.D.  
MICHAEL F. MCGRATH, M.D.  
KIRK J. FLEISCHER, M.D.  
JONATHAN M. PHILPOTT, M.D.  
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**MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD.**

SENTARA HEART HOSPITAL  
600 GRESHAM DRIVE  
SUITE 8600  
NORFOLK, VIRGINIA 23507  
(757) 388-6005

www.macts.com  
email: macs@macts.com

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LENOX D. BAKER, JR., M.D.  
WAYNE M. DERKAC, M.D.

ADMINISTRATION  
DEBRA D. INGE

BILLING MANAGER  
KATHY ORRELL

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

**AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION**

I authorize MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD. to obtain any medical information necessary for my treatment and/or to release information needed to process insurance claims for such treatment.

**AUTHORIZATION TO ASSIGN BENEFITS**

I authorize payment of the medical benefits for services rendered to MID-ATLANTIC CARDIOTHORACIC SURGEONS, LTD.

**PAYMENT POLICY**

I understand that filing of my insurance by Mid-Atlantic Cardiothoracic Surgeons, Ltd. is done as a courtesy; and that I am financially responsible for any balance remaining. In the event that my account is referred to a collection agency, I agree to pay all costs of collection including the agency's fee of 33 $\frac{1}{3}$ % of the balance owed on referral.

Signature of insured or authorized person \_\_\_\_\_ Date \_\_\_\_\_

PLEASE LIST ALL INFORMATION BELOW OR ATTACH A COPY OF YOUR CARD(S)

Name of Company \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber SS# \_\_\_\_\_

Insured ID \_\_\_\_\_ Policy # \_\_\_\_\_

Group Name \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_\_

IF YOU HAVE OTHER INSURANCE POLICIES, PLEASE PROVIDE INFORMATION ON THE REVERSE SIDE OF THIS FORM AND NOTE WHICH POLICY IS PRIMARY.

IF YOU HAVE MEDICARE, DOES YOUR CARD STATE "MEDICAL INSURANCE"? YES / NO

Thank you very much.

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## 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 MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We understand that medical information about you and your health is personal, and we are committed to protecting that information. We create a record of the care and services you receive at Mid-Atlantic Cardiothoracic Surgeons, Ltd., in order to provide you with quality care and to comply with certain legal requirements.

This Notice of Privacy Practices describes how we may use and disclose medical information about you, including demographic information, that may identify you and your related health care services to carry out your treatment, obtain payment for our services, perform daily health care operations of this practice, and for other purposes that are permitted or required by law. This notice also describes your rights to access and control your medical information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you would not like messages left on your answering machine please let us know.

We will also disclose your medical information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we

have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer, Sandra Ronan:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

**We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.**

**This notice is effective as of April 14, 2003** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

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## **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

Mid-Atlantic Cardiothoracic Surgeons, Ltd. must make a good faith effort to obtain an individual's written acknowledgement that he/she has received the Notice of Privacy Practices.

Acknowledging receipt of the Notice of Privacy Practices with your signature does not imply agreement or disagreement with this policy, just receipt of said policy.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Social Security #