



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Please circle your answers**

Are you a:

Current Smoker

Former Smoker

Nonsmoker

Use Tobacco in other forms?

Are you experiencing any of the following?

Food Insecurity

Housing Instability

Interpersonal Safety

Transportation Needs

Utility Difficulties

Did you have a drink containing alcohol in the past year?

Yes **If 'Yes' :**

No How often did you have a drink containing alcohol in the past year?

Never (0 point)

Monthly or less (1 point)

2 to 4 times a month (2 points)

2 to 3 times a week (3 points)

4 or more times a week (4 points)

**If 'Yes' :**

How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 drinks (0 point)

3 or 4 drinks (1 point)

5 or 6 drinks (2 points)

7 to 9 drinks (3 points)

10 or more drinks (4 points)

**If 'Yes' :**

How often did you have 6 or more drinks on one occasion in the past year?

Never (0 point)

Less than monthly (1 point)

Monthly (2 points)

Weekly (3 points)

Daily or almost daily (4 points)

**PATIENT INFORMATION FORM**

Name (last, first, middle): \_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

preferred call method

preferred call method

Email Address: \_\_\_\_\_  DO NOT enroll me in the online health portal

Gender: Male / Female Marital Status: Single / Married / Widowed / Divorced / Separated

Occupation: \_\_\_\_\_ Work Status: Employed / Unemployed / Retired / Disabled

**Race (please check one)**

- Not specified / Other
- Native American or Alaskan Native
- Asian
- Black or African American
- Hawaiian Native or Other Pacific Islander
- White

**Ethnicity (please check one)**

- Not specified / Other
- Hispanic or Latino
- Not Hispanic or Latino

Preferred Language: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Reason for Today's Visit:** \_\_\_\_\_

**Emergency Contact**

Name (last, first, middle): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ home / cell Email Address: \_\_\_\_\_

Name (last, first, middle): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ home / cell Email Address: \_\_\_\_\_

*\*Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

**Communication Preferences**

Endovascular Consultants of Colorado contacts patients for a variety of reasons, including appointment reminders and providing test results. Please let us know how you prefer us to communicate with you.

Please DO NOT contact me at the following (check all that apply):

Cell Phone

- Reminder Calls
- Voicemail
- Text Reminders - SMS (standard charges may apply)

Home Phone

- Reminder Calls
- Voicemail

Patient Portal

- Appointment Reminders
- General Notifications

**Patient Consent to Release Protected Health Information**

Authorized by:

Patient \_\_\_\_\_ Legal Guardian/POA: \_\_\_\_\_

Disclose my Protected Health Information to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

This authorization is in force until:

\_\_\_ It is cancelled in writing

\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

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**Insurance Information**

**PLEASE HAVE YOUR PHOTO ID & INSURANCE CARDS AT EVERY VISIT. ALL COPAYS ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

**Primary Insurance**

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

**Secondary Insurance**

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

**Tertiary Insurance**

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

\_\_\_\_\_  
 Patient Name (Please Print)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Relationship to Patient

*\*Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*



Endovascular Consultants of Colorado  
8080 Park Meadows Drive, Suite 150  
Lone Tree, CO 80124  
720-668-8818 office | 877-229-5440 fax

## Only Applicable for Patients with UnitedHealthcare

Dear ECCO Medical Patients,

We are writing to inform you that based on your current insurance plan with UnitedHealthcare, there is a possibility that certain medical services, specifically those coded as 37252 and 37253, may not be covered by your insurance. ECCO Medical follows all of UnitedHealthcare’s guidelines including obtaining prior authorization for full approval. Even when we've maximally complied, UnitedHealthcare may still deny payment, even when we provide evidence of maximum compliance.

What this means for you:

**Potential out-of-pocket costs:**

Depending on your plan details, you may be responsible for a significant portion of the cost for these services, including the full price of the codes 37252 and 37253 which is approximately \$1,250.00

**Prior authorization required:**

In some cases, even if your insurance plan technically covers the service, you may need to obtain prior authorization from your insurance company before receiving treatment.

**Contact your insurance company:**

We strongly recommend reaching out to UnitedHealthcare directly to verify your coverage for the specific CPT codes relevant to your upcoming treatment plan. Our schedulers can provide you with a list of the CPTs specific to your procedure. The phone number for your insurance company should be listed on your insurance card. You can also ask your insurance company how to proceed with a benefit appeal.

**Discuss options with your provider:**

Please discuss your concerns and potential cost implications with your healthcare provider to explore payment plan options.

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Patient Signature

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Date of Signature

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Patient Printed Name

Sincerely,

ECCO Medical

### **Patient Financial Policy**

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between YOU/YOUR INSURANCE COMPANY/YOUR EMPLOYER. (Please refer to enclosed document-“Understanding Your Insurance Coverage”) Not all services are covered by all contracts.

We participate and accept assignment from most major payers, which means covered charges will be paid directly to us. If we do not participate in your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received a remittance from your insurance carrier.

Due to current federal and insurance regulations, ALL co-payments, co-insurance and deductibles are collected at the time of service. We accept Visa, American Express, MasterCard, and Discover and in certain situations will accept a personal check made out to our office. Additional fees, which typically are not covered by insurance plans, will be charged for services such as copying of medical records and completion of disability forms. A fee of \$35.00 will be charged for checks returned for insufficient funds. An additional monthly fee may be charged on all past due accounts and co-pays not paid at time of visit. We encourage you to contact our **Billing Company** promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

### **Patient Financial Agreement**

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for ANY professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

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Patient Signature

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Patient Name (printed)

---

Date

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Have you received a flu shot this year? \_\_\_\_\_ Have you received a pneumonia shot this year? \_\_\_\_\_

Have you fallen in the past year? \_\_\_\_\_ If yes, how many times? \_\_\_\_\_

What was the reason for the falls? \_\_\_\_\_

What is your current height? \_\_\_\_\_ What is your current weight? \_\_\_\_\_

**Surgical History**

Surgery	Year	Location/Facility

**Prior Anesthesia Complications?**

No  Yes; Please explain: \_\_\_\_\_

**Personal Medical History**

Please check any of the following health problems you have had or have now:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Stroke or Mini Stroke	<input type="checkbox"/> Emphysema (COPD)	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Pain in legs with walking	<input type="checkbox"/> Stomach Reflux/Heartburn	<input type="checkbox"/> Aneurysm Location: _____
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Problems/Failure	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Diabetes Type: _____
<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Pacemaker/ICD	<input type="checkbox"/> Bleeding or Clotting Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Varicose Veins/Vein Stripping	<input type="checkbox"/> Abnormal Heart Rhythm/Atrial Fibrillation	<input type="checkbox"/> Other: _____

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Other Health Issues**

Smoking Status:  Never  Quit, when? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

Current Smoker; how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

If current or past, what type?  Cigarettes  Cigars  Pipe  Chewing Tobacco

Do you use any recreational drugs?  No  Yes; which ones? \_\_\_\_\_

Do you drink alcohol?  No  Yes;  Wine  Beer  Liquor How many per week? \_\_\_\_\_

Is violence at home a concern for you?  No  Yes

Do you require the use of:  Cane  Walker  Wheel Chair

**Known Allergies to Food or Medication**

No Allergies

Medical Contrast Dye  Iodine  Choloraprep  Adhesive/Tape  Latex

Allergy and Reaction: \_\_\_\_\_

Allergy and Reaction: \_\_\_\_\_

Allergy and Reaction: \_\_\_\_\_

**Preferred Lab for Blood Work**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Do you take any of the following:**

Coumadin/Warfarin  Xarelto  Clipidogrel/Plavix  Apixaban/Eliquis  Aspirin  Pradaxa

Who manages lab work? \_\_\_\_\_ Location: \_\_\_\_\_

**Preferred Pharmacy**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Current Medications**

Please list prescription and non-prescription medications, vitamins, cold remedies, and herbals.

Medication Name and Purpose	Dosage (Amount)	Frequency (How often)

**Family Medical History**

Please check if the following health problems affect your family and identify their relationship to you (mother, father, brother, sister, grandparent – specify maternal/paternal or child).

<input type="checkbox"/> Alcohol/Drug Abuse _____	<input type="checkbox"/> Emphysema/COPD _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Bleeding Problem _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Blood Clots _____	<input type="checkbox"/> High Cholesterol _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Obesity _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Depression / Anxiety _____	<input type="checkbox"/> Thyroid Problems _____
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Varicose Veins _____
<input type="checkbox"/> Dialysis _____	<input type="checkbox"/> Other: _____

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Review of Systems**

Please check all that apply:

	<b>Constitution</b>	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Unexpected weight change
	<input type="checkbox"/> Other: _____	
	<b>Respiratory</b>	
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Home oxygen	<input type="checkbox"/> Asthma	
	<input type="checkbox"/> Other: _____	
	<b>Cardiovascular</b>	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Myocardial Infarction
	<input type="checkbox"/> Other: _____	
	<b>Gastrointestinal</b>	
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Nausea
	<input type="checkbox"/> Other: _____	
	<b>Genitourinary</b>	
<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Frequency
<input type="checkbox"/> Hematuria	<input type="checkbox"/> Scrotal swelling	<input type="checkbox"/> Urgency
<input type="checkbox"/> Urine decreased	<input type="checkbox"/> Other: _____	

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<b>Musculoskeletal</b>		
<input type="checkbox"/> Arthralgias	<input type="checkbox"/> Back pain	<input type="checkbox"/> Joint swelling
	<input type="checkbox"/> Other: _____	
<b>Skin</b>		
<input type="checkbox"/> Color change	<input type="checkbox"/> Rash	<input type="checkbox"/> Wound
	<input type="checkbox"/> Other: _____	
<b>Neurological</b>		
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Light-headedness
	<input type="checkbox"/> Other: _____	
<b>Hematological</b>		
<input type="checkbox"/> Adenopathy	<input type="checkbox"/> Bruises/bleeds easily	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Other: _____	

**GYN (Females Only)**

Date of Last Menstrual Cycle: _____	Age of First Menstruation: ____ Age of Menopause: ____
Total Number of Pregnancies: _____	Number of Live Births: _____
Pregnancy Complications: _____	

\_\_\_\_\_  
 Patient Name (Please Print)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Relationship to Patient

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# Endovascular Consultants of Colorado, PC

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it carefully, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with; payment is expected at each visit. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failing to collect co-payments and deductibles could violate our insurance contracts with federal and private insurance companies.
3. **Non-Covered Services.** Please be aware that some — and perhaps all — of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services at the time of your visit.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claim Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage Changes.** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits.

Thank you for your understanding of our payment policy. Please let us know if you have any questions or concerns.

**I have read and understood the above information, and agree to accept the conditions:**

\_\_\_\_\_  
**Signature of patient or responsible party**

\_\_\_\_\_  
**Date**

### Your Health Information Rights

**The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:**

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI;
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

### **Our Responsibilities**

#### **The Practice is required to:**

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice (“Notice”) describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

### **Other Uses and Disclosures of your PHI**

#### **Communication with Family**

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

#### **Notification**

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

### **Research**

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

### **Disaster Relief**

- We may use and disclose your PHI to assist in disaster relief efforts.

### **Organ Procurement Organizations**

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

### **Food and Drug Administration (FDA)**

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

### **Workers' Compensation**

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

### **Public Health**

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

### **As Required by Law**

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

## **Employers**

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

## **Law Enforcement**

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

## **Health Oversight**

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

## **Judicial/Administrative Proceedings**

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

## **For Specialized Governmental Functions or Serious Threat**

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

## **Correctional Institutions**

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

### **Coroners, Medical Examiners, and Funeral Directors**

- We may release health information to a coroner or medical 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 our Patients to funeral directors as necessary for them to carry out their duties.

### **Website**

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights."

### **To Request Information, Exercise a Patient Right, or File a Complaint**

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at 720-668-8818, or in writing to us at this address:

Practice Manager

8080 Park Meadows Dr. Suite 150

Lone Tree, CO 80124

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address.

You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019.

More information regarding the steps to file a complaint can be found at:

[www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints).

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of

HHS as a condition of receiving treatment from the Practice.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Patient (or Patient Representative\*) Signature

\_\_\_\_\_

Date

---

### For Practice Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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\*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

## Understanding Your Insurance Coverage

Your insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs, and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called “covered services.”

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy.

Insurance companies determine what tests, drugs and services they will cover. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company’s choices may mean that the test, drug or service you need isn’t covered by your policy.

Your doctor will try to be familiar with your insurance coverage so he/she can provide you with covered care. However, there are so many different insurance plans that it is not possible for your doctor to know the specific details of each plan. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered in your plan.

- Take the time to read your insurance policy. It’s better to know what your insurance company will pay for before you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Remember that your insurance company, not your doctor, makes the decisions about what will be paid for and what will not.
- Remember that your doctor, not your insurance company, makes medical decisions and recommendations about what will benefit your health status.

Most of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn’t covered, or you get a prescription filled for a drug that isn’t covered, our insurance company won’t pay the bill. This is often called “denying the claim.” You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company’s appeal process. This should be discussed in your plan book.

**Information Release and Consent to Treatment  
Insurance Authorization for Assignment of Benefits**

I, the undersigned, authorize payment of medical services to Endovascular Consultants of Colorado for any services furnished to me by the physician/s. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I understand that if I engage with my health care provider in any form of telemedicine consultation (which can include but is not limited to telephone, video, or any type of digital conference as long as it is approved, secured and HIPAA compliant) my insurance will be billed accordingly for all such telehealth visits.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care, medical examinations including telemedicine, operations, procedures, therapy sessions, photographs, and/or treatment by my attending physician, their assistants, or designees as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, medical examinations, operations, procedures, therapy sessions and/or treatments.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Patient Name (printed please)

Endovascular Consultants of Colorado endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

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Patient Name (Please Print)

\_\_\_\_\_

Date

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Patient/Guardian Signature

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Relationship to Patient

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