JAMES H. LEE, MD FACS
1177 E. WARNER AVE
FRESNO, CA 93710
OFFICE PHONE: 559-702-1390
OFFICE FAX: 619-519-7073
INFO@VCIFRESNO.COM

NEW PATIENT REGISTRATION

PATIENT INFORMATION:

PATIENT NAME: ____DOB: _____/_____/________

GENDER: ☐ MALE ☐ FEMALE SOCIAL SECURITY NUMBER ______-____-________

HOME ADDRESS:

____

ADDRESS CITY ZIP CODE

PRIMARY NUMBER: (☐ MOBILE ☐ HOME) ___________________

SECONDARY NUMBER (☐ MOBILE ☐ HOME) _____________________

E-MAIL ADDRESS: _________________________________ PREFERRED LANGUAGE: ___________

EMERGENCY CONTACT/NEXT OF KIN

THE INDIVIDUAL LISTED BELOW IS TO BE CONTACTED ONLY IN THE EVENT OF AN EMERGENCY.

CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER	PERMISSION TO DISCUSS MEDICAL CONDITION
		( )	YES/NO INITIALS: _______

REFERRING PROVIDER INFORMATION

REFERRING PROVIDER: ______________________________________ SPECIALTY: ______________

PHONE NUMBER: _____________________________

OFFICE ADDRESS: ____

PRIMARY CARE PHYSICIAN: ____

CARDIOLOGIST (HEART SPECIALIST)

PHYSICIAN NAME: __________________________

OFFICE NUMBER: ___________________________

ADDRESS: ____

VASCULAR CENTER OF INTERVENTION

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PHARMACY INFORMATION

PHARMACY NAME: ______________________________ ADDRESS: _______________________________

PHARMACY PHONE: _____________________________________

MEDICATION

LIST ALL MEDICATIONS YOU TAKE PRESCRIPTION AND NON- PRESCRIPTION.

☐I DO NOT TAKE ANY MEDICATION

MEDICATION NAME	DOSAGE (mg, mL, mcg ETC.)	FREQUENCY (DAILY, 2X A DAY, 3X A DAY, AS NEEDED ETC.)

ALLERGIES (PLEASE INCLUDE REACTIONS)

☐NO KNOWN ALLERGIES

MEDICATION: ____

FOOD/SHELLFISH: ____

CONTRAST DYES: ________________________ ALLERGIES TO TAPE: _______________________

VCI
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MEDICAL HISTORY

CHECK IF YOU HAVE EVER EXPERIENCED THE FOLLOWING CONDITIONS/ RISK FACTORS)

☐ **NOT APPLICABLE**

CONDITION	YEAR
☐ AIDS	
☐ AORTIC ANEURYSM	
☐ CANCER	
☐ CLOTTING DISEASE	
☐ CONGESTIVE HEART FAILURE	
☐ CORONARY ARTERY DISEASE	
☐ DIABETES TYPE 1	
☐ DIABETES TYPE 2	
☐ HEART DISEASE	
☐ HEPATITIS (CIRCLE: A, B, C)	

CONDITION	YEAR
☐ HIGH BLOOD PRESSURE	
☐ HIGH CHOLESTEROL	
☐ HIV	
☐ IRREGULAR HEARTBEAT	
☐ KIDNEY DISEASE	
☐ LUNG DISEASE	
☐ MRSA	
☐ PACEMAKER	
☐ PNEUMONIA	
☐ STROKE	

OTHER MEDICAL PROBLEMS:

____

SURGICAL HISTORY

☐ **NOT APPLICABLE**

CONDITION	YEAR
☐ APPENDECTOMY	
☐ BACK OR NECK	
☐ CESAREAN SECTION	
☐ GALLBLADDER	

CONDITION	YEAR
☐ HERNIA	
☐ HEART/VASCULAR	
☐ HYSTERECTOMY	
☐ HIP OR KNEE REPLACEMENT	

OTHER SURGERIES:

____

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VASCULAR PROCEDURES/STUDIES

☐ **NOT APPLICABLE**

CONDITION	YEAR
☐ AMPUTATION	
☐ ANGIOGRAM	
☐ ANGIOPLASTY (HEART/LUNG)	
☐ ANGIOPLASTY W/ STENTING	
☐ ANEURYSM REPAIR	
☐ CARDIAC CATHETERIZATION	
☐ BYPASS OF LEG	

CONDITION	YEAR
☐ CARDIAC STRESS TEST	
☐ CT SCAN	
☐ ECG/EKG	
☐ FOOT EXAM	
☐ MRI	
☐ ULTRASOUND (HAND/LEGS)	
☐ PACEMAKER	

FAMILY HISTORY OF VASCULAR DISEASE

(CHECK IF ANY FAMILY MEMBERS HAS HAD ANY OF THE FOLLOWING CONDITIONS.)

☐ **ADOPTED** ☐ **UNKNOWN**

DIAGNOSIS	FATHER	MOTHER	BROTHER	SISTER	OTHER
AORTIC ANEURISM					
CAD (HEART ATTACK)					
CANCER					
CVA (STROKE)					
DIABETES					
HIGH BLOOD PRESSURE					
HIGH CHOLESTEROL					
HEART DISEASE					
KIDNEY/RENAL DISEASE					
PERIPHERAL VASCULAR DISEASE					
VARICOSE VEINS					

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PATIENT INFORMATION

RACE:

☐ AMERICAN INDIAN OR ALASKAN NATIVE

☐ ASIAN

☐ BLACK OR AFRICAN AMERICAN

☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

☐ WHITE

☐ OTHER (PLEASE SPECIFY): ______________________

ETHNICITY:

☐ HISPANIC/LATINO

☐ NON-HISPANIC

☐ OTHER (PLEASE SPECIFY): ______________

SOCIAL HISTORY

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐DOMESTIC PARTNER # OF CHILDREN: _____

WORK: ☐EMPLOYED ☐UNEMPLOYED ☐RETIRED ☐DISABLED

OCCUPATION: ___________________________ FORMER OCCUPATION _____________________

TOBACCO: ☐NONE ☐YES CHEW OR SMOKE HOW MANY PER DAY_______ SINCE_____________

PAST USE: ☐ YES ☐ NO QUIT DATE: _________________

ALCOHOL: ☐NONE ☐YES HOW MANY DRINKS PER DAY?_________ FREQUENCY:____________

PAST USE: ☐ YES ☐ NO QUIT DATE: _________________

RECREATIONAL DRUG USE: ☐NONE ☐YES SPECIFY DRUGS ______________________________

PAST USE: ☐ YES ☐ NO QUIT DATE: _________________

EXERCISE ACTIVITY: ☐ SEDENTARY ☐ MODERATE ☐ VIGOROUS DAYS/WEEK: _________________

IMMUNIZATION HISTORY

FLU VACCINE: ☐ YES ☐ NO (MONTH/YEAR) _____________________

LOCATION: ☐ PRIMARY ☐ CLINIC ☐ HOSPTIAL ☐ OTHER: ______________

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ADVANCED DIRECTIVE

LEGAL WRITTEN STATEMENT OF THE PATIENT'S WISHES REGARDING MEDICAL TREATMENT IF YOU'RE TOO ILL TO SPEAK FOR YOURSELF.

DO YOU HAVE AN ADVANCED DIRECTIVE: ☐ YES ☐ NO

MEDICAL POWER OF ATTORNEY

LEGAL DOCUMENT GRANTING SOMEONE YOU TRUST AUTHORITY TO MAKE MEDICAL DECISIONS IF YOU ARE UNCONSCIOUS, MENTALLY INCOMPETENT, OR OTHERWISE UNABLE TO MAKE DECISIONS ON YOU OWN.

HAVE YOU ESTABLISHED A MEDICAL POWER OF ATTORNEY: ☐ YES ☐ NO

NAME:____

RELATION TO PATIENT:_________________________________

CONTACT PHONE NUMBER:______________________________

IF YOU MARKED <u>YES</u> TO THESE QUESTIONS, PLEASE PROVIDE A COPY.

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RELEASE OF MEDICAL RECORDS

Patient Name: ____ DOB: ___________________

I________________________________, (Patient) authorize the release of my personal medical records, media and/ or billing information to the following facilities and/ or persons:

Vascular Center of Intervention (VCI)

1177 E. Warner Avenue

Fresno, CA 93710

Phone: 559-702-1390 Fax: (619) 519 -7073

I understand that by singing this release, Vascular Center of Intervention and its affiliated doctors have my approval to release my person medical records as noted above. I understand that this medical release will remain effect unless revoked by me in writing.

PRINT NAME: ____ Date: ______________

SIGNATURE: ____

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PERMISSION TO PHOTOGRAPH

I hereby grant Vascular Center of Intervention (VCI) permission to take a digital photo of me.

I understand that:

- The photo will be stored permanently in my medical record.
- The photo will be used to identify me when I come to VCI for medical care.
- The photo will be stored securely to protect my privacy.
- The photo will NOT be used outside of VCI, unless I, or my legal representative, give my permission in writing.
- VCI will own the photo. I can look at the photo, or get copies, if I, or my legal representatives, sign a release form.

PRINT NAME: ____ Date: ____________

SIGNATURE: ____

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VASCULAR CENTER OF INTERVENTION (VCI) FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment bring successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our patient information and insurance information forms prior to seeing the physician(s). **Co-pays, deductibles, and non-covered services are due at time of service.** We accept cash, checks, and all major credit cards. We may accept assignment of insurance benefits. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all of the services provided may be non-covered services, which you will be liable for if unpaid.

PAYMENT GUARANTEE: The undersigned severally agree, whether signing as a patient or guarantor, to guarantee payment of the account in accordance with the standard rates and terms. I understand that my insurance, if any, is a contract between the insurance company, and myself except in certain cases where **Vascular Center of Intervention** (VCI) has a specific contract with my PPO, HMO, or other third-party payer. **I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay, including any amount not paid by a secondary or supplemental insurance policy.**

- If full payment is not received within 60 days of billing, VCI reserves the right to charge interest of 2.5% per month per visit (18% APR) or the highest rate allowed by law. In addition to interest charges a late fee of $10.00 will be applied if not paid in 60 days. All balances over 180 days past due will be subject to be turned over to collections.

- In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), you agree to be responsible for and pay, in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collection fees, attorney fees, court costs, and contingent fees to collection agencies of not less than thirty-five percent (35%).

- VCI reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions and who may report unpaid balances to credit bureaus.

- The provider of service has the right to terminate services based on noncompliance of all or any office agreements and policies.

- In the event that a patient is considered "Out of Network" all payments paid directly to the patient must be authorized and checks/payment delivered to VCI. Failure to assign the payments to VCI will result in the above mentioned collections process.

RELEASE OF INFORMATION: I hereby authorize VCI to release all medical information (including, but not limited to information relating to mental health evaluation and treatment, sickle cell anemia, alcohol and drug abuse diagnosis and treatment. HIV status, AIDS or AIDS related diagnosis, if any such information exists) to other health care providers, all my agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Workers' Compensation or for other insurance purposes.

NOTICE OF PRIVACY PRACTICE: I acknowledge receipt of the Notice of Privacy Practices (HIPAA). I have read, understand and have access to a copy of VCI's Notice of Privacy Practices.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize the payment of any insurance or other medical benefits directly to **Vascular Center of Intervention - Dr. James Ho Lee, MD.**

MEDICARE ASSIGNMENT: **If you have Medicare, you authorize the following:** I request that payments of authorized Medicare benefits be made either to me or on my behalf to: Vascular Center of Intervention. For any services

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furnished to me by that physician(s) of supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance coverage is indicated in the 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physicians or supplier agrees to accept the changes determination of the Medicare carrier as the full charge and the patient is responsible only for the deductive, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determined of the Medicare carrier. I also request payment of government benefits either to myself or the party who accepts assignment below.

CANCELLATION POLICY

CANCELLATION OR RESCHEDULING OF A SURGERY, PROCEDURE OR OFFICE VISIT: Cancellation of surgeries, procedures, office appointments, and no shows are taken seriously at VCI. We understand that there are unforeseen circumstances, which will require rescheduling of your appointment. Please understand cancellation of surgeries, procedures, and office appointments results in loss of staff resources and time, which are provided for the care of V.C.I. patients. If cancellation or rescheduling is required please notify us in a timely manner. Thank you for your understanding

For all non Medi-cal members, there will be a charge of $40.00 for all surgeries and procedures that are cancelled, rescheduled or No-Showed with less than 48-hour notice. A charge of $20.00 for a clinic or ultrasound cancellation with less than 24-hour notice or no show.

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PATIENT RIGHTS AND RESPONSIBILITIES

Vascular Center of Intervention (VCI) has adopted the following list of *Rights and Responsibilities for Patients:*

PATIENT RIGHTS

1. Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment.
2. Considerate and respectful care.
3. Knowledge of the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians who will see you.
4. Receive information from your physician about your illness, your course of treatments and your prospects for recovery in terms that you can understand.
5. Receive as much information about proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out this procedure.
6. Participate actively in decisions regarding your medical care. To extent permitted by law, this includes the right to refuse treatment.
7. Full consideration of privacy concerning your medical program. Case discussion, consultation examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual.
8. Confidential treatment of all communication and records pertaining to your care and visit to VCI. Your written permission shall be obtained before your medical records can be made available to anyone not directly concerned with your care.
9. Reasonable responses to any reasonable request you may make for services.
10. Right to leave VCI even against the advice of your physician.
11. Reasonably continuity of care and to know in advance the time and location of appointment as well as the physician providing care.
12. Be advised if VCI/physician proposed to engaged in or perform human experimentation affecting your care or treatment. The patient has the right to refuse to participate in such research projects.
13. Be informed by your physician or a delegate of your physician of our continuing health requirements following your discharge from VCI.
14. Examine and receive an explanation of your bill regardless or source of payment.
15. Know the rules and policies that apply to your conduct as a patient.
16. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

PATIENT RESPONSIBILITIES

The care a patient receives depends partially on the patient him/herself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities shall be presented to the patient in the spirit of mutual trust and respect.

1. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history and others matters relating to his/her health, including but not limited to current illnesses such as hepatitis, HIV and other transmittable diseases.
2. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.

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3. The patient is responsible for following the treatment plan established by his/her physicians, including the instruction of nurses and other health professional as they carry out the physician's orders. The patient should express any concern they have about following the proposed care plan.
4. The patient and family are responsible for the outcomes if they do not follow the care plan.
5. The patient is responsible for keeping appointments and for notifying VCI when he/she is unable to do so.
6. The patient is responsible for his/her actions should he/she refuse treatment or not follow orders.
7. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
8. The patient is responsible for following facility policies and procedures.
9. The patient is responsible for being considerate of the rights of other patients and facility personnel.
10. The patient is responsible for being respectful of his/her personal property and other persons in the lab.

Section 70707, Title 22
California Administrative Cod

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EFFECTIVE DATE: 09/08/2015

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 health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

VCI Office Manager at the address and phone number listed above.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain

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payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Optional Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Optional Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Optional Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Optional Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees, or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only

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if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:
- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death, we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Optional Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Optional Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. Optional Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
(B) The research could not practicably be conducted without the waiver,
(C) The research could not practicably be conducted without access to and use of the PHI.
8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:
1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we

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contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to VCI Office manager specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to VCI Office Manager at the address and number listed above. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to VCI Office Manager at the address and number listed above in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to VCI Office Manager at the address and number listed above. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to VCI Office Manager at the address and number listed above. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact VCI Office Manager.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our

VASCULAR CENTER OF INTERVENTION
JAMES H. LEE, MD FACS
1177 E. WARNER AVE
FRESNO, CA 93710
OFFICE PHONE: 559-702-1390
OFFICE FAX: 619-519-7073

practice, contact VCI Office Manager at the address and phone number listed above. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **VCI Office Manager at the address and phone number listed above.**

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INFO@VCIFRESNO.COM

Office Policies and Privacy Practice Notice

By initialing and signing below I have read and agree by Vascular Center of Intervention (VCI) office policies and wish to continue care.

VASCULAR CENTER OF INTERVENTION (VCI) FINANCIAL POLICY

Initials: _________ The undersigned certifies that he/she has read, or has been read, the foregoing, that he/ she understands the foregoing, that he/she has received a copy/or has access to a copy thereof, that he/she has been given the opportunity to ask any questions that he/she may have concerning the foregoing, and that he/she is the patient or duly authorized representative of the patient. the undersigned, having read and understood the agreements, accepts the financial responsibility agreement, the release of information agreement, notice of privacy practice, the authorization to pay insurance benefits, the authorization to deposit checks and Vascular Center of Intervention office policies.

CANCELLATION POLICY

Initials: _________ Please note that once you have scheduled an appointment with us it means that we have reserved time in our schedule exclusively for you. If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a **no-show fee of *$20* for all clinic and ultrasound visits. There will be also be a charge of *$40.00* for all surgeries and procedures that are not cancelled within a 24 hours' notice.**

To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your appointment. **You can cancel or reschedule an appointment by calling our office at 559-702-1390, texting 559-979-0000, or simply leaving a voicemail.**

PATIENT RIGHTS AND RESPONSIBILITIES

Initials: _________ I acknowledge the receipt of VCI'S policies on my rights and responsibilities as a patient. I clearly understand what is written in this document, and any questions and/or grievances regarding my rights and responsibilities as a patient should be addressed to VCI'S office manager.

NOTICE OF PRIVACY PRACTICES

Initial: __________ I hereby acknowledge receipt of Vascular Center of Intervention's Notice of Privacy Practices.

Print Name: ____ Date: _________

Signature: ____