



THE HEART INSTITUTE

OF EAST TEXAS, P. A.

Specializing in Heart & Vascular Care Since 1982.

Acknowledgement of Review of Privacy Practice

I have reviewed this office's *Notice of Privacy Practice* which explains how my medical information will be used and disclosed. I have been given the opportunity to ask questions if I do not understand.

I understand that I am entitled to receive a copy of this document.

Signature of Patient or Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Ravinder Bachireddy, MD

Kevin L Hudson, DO

J S Chandra, MD

M. Musa Khan, MD

Venkata R Kovvali, MD

Cheriparambil K Mani, MD

Ilyas M Khan, MD

Aditya Saini, MD

Yugandhar Manda, MD

Mikhail Narezkin, MD

George Vettiankal, MD

Subramanya Venkata, MD

Jamie Huckabee, APRN, NP-C, AACC

Adam Merritt, APRN, NP-C

Daniel Morris, APRN, NP-C



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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____



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Medical Records Release Form

To: _____
Doctor or Hospital

Address

I hereby authorize and request you to release to:

Name: _____

Address: _____

Phone: _____ Fax: _____

The complete medical records in your possession concerning my illness and/or treatment:

Records Requested: _____

Time Period: _____ To: _____

Reason for release: _____

I understand that this authorization authorizes the release of all medical records including psychiatric, alcohol, drug abuse, and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, section 408; Public Law 93-282, Section 333; federal Regulation 421 CFR, Part 2. The information provided is confidential and any disclosure by the recipient is prohibited.

Patient or Nearest Relative

Relation to Patient

Witness

Date

Printed name of patient

Patient's date of birth

SSN

Ravinder Bachireddy, MD	Kevin L Hudson, DO	Ilyas M Khan, MD	Aditya Saini, MD
J S Chandra, MD	M. Musa Khan, MD	Yugandhar Manda, MD	Mikhail Narezkin, MD
Venkata R Kovvali, MD	C K Mani, MD	George Vettiankal, MD	Subramanya Venkata, MD



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You have the right to receive a “Good Faith Estimate” explaining how much your health care will cost

Under the law, health care providers need to give **patients who don’t have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the healthcare provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity’s compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.