

Hudson Valley Diagnostic Imaging P.C.

CT, Ultrasound, X-ray, Bone Densitometry and Mammography

Andrew Lewis M.D. Radiologist

MR #: _____

INS. AUTH. # _____

EMPLOYEE INITIALS _____

PATIENT INFORMATION

Heard about us through: _____

DATE: ____/____/____

Last Name: _____ First Name: _____ Sex: M F

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: ____/____/____ Age: ____ Social Security #: _____

Employer: _____ Phone: (____) _____

Referred By: _____ Primary Physician: _____

INSURER INFORMATION (if different from above)

Last Name: _____ First Name: _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: ____/____/____ Social Security #: _____

Employer: _____ Phone: (____) _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Copay: _____

Address: _____ Phone: (____) _____ - _____

City: _____ State: _____ Zip: _____

ID/Certificate #: _____ Group #: _____

Policy Holder Name: _____ Relationship: _____

Secondary Insurance Company Name: _____ Copay: _____

Address: _____ Phone: (____) _____ - _____

City: _____ State: _____ Zip: _____

ID/Certificate #: _____ Group #: _____

Policy Holder Name: _____ Relationship: _____

CPT: Service:	CPT: Service:	CPT: Service:
Code: Diagnosis:	Code: Diagnosis:	Code: Diagnosis:

Patient Signature: _____ Date: ____/____/____

310 North Highland Avenue (Route 9) Suite 3, Ossining, New York 10562

Phone: 914 923-0201 Fax: 914 923-0209



Hudson Valley Diagnostic Imaging P.C.

NOTICE OF PRIVACY PRACTICES

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.

Our Duties:

We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all medical information we maintain. A copy of our revised notice will be available from our Privacy Coordinator by calling (914) 923-0201, or by writing to *Hudson Valley Diagnostic Imaging P.C.*, c/o Privacy Coordinator, 310 North Highland Avenue, Suite 3, Ossining, NY, 10562. You may also address questions regarding our privacy practices, your privacy rights, or requests for additional information regarding your privacy to this person.

Permitted Uses and Disclosures:

We may use and discuss your medical information in the ordinary course of our business. We have described some of these uses and disclosures in the following paragraphs:

- **Treatment:** We will provide your doctor or other health care provider with the results of the diagnostic imaging exams we perform. We may contact you before the exam to remind you of your appointment or to talk to you about preparing for the exam. We normally call you at the contact number you provide to us. If you are not available or your voice mail answers, we will leave a brief message reminding you of the place and time of your appointment. If applicable, we will ask you to call us regarding your exam preparations.
- **Payment:** We will bill your insurance company, you directly, or another person that may be responsible for payment of your account. We may need to contact your health plan to see if they will pay for the exams your doctor has ordered. Throughout this process, we may have to release details of your exam and medical condition, if your health plan or other payor requires this information to make payment.
- **Health Care Operations:** We often have to use specific patient information to conduct our normal business operations. For example, we routinely review past exams performed to maintain quality assurance goals. One type of review we may conduct includes selecting images for review by another radiologist. Another is to select your billing information for review by our internal compliance team, or by external auditors. In addition, we may use specific patient information to demonstrate our skills to an accreditation body. Accreditation is important to our patients and to us because the process causes us to demonstrate some degree of proficiency in conducting examinations and maintaining the quality of our equipment.

Disclosures without Authorization:

We may use and disclose medical information about you, without your specific authorization, as follows:

- **Disclosures Required by Law:** We may be required by Federal, State, or local law to disclose your medical information.
- **Public Health Activities:** We may disclose your medical information to a public agency, such as the Food and Drug Administration (FDA), if you experience an adverse effect from any of the drugs, supplies, or equipment we use.
- **Victims of Abuse, Neglect, or Domestic Violence:** We may be required to disclose your medical information if we feel that you have been abused or neglected.
- **Health Oversight Activities:** We may be required to disclose your medical information to Medicare or a related agency if they select your case for a medical review.
- **Judicial and Administrative Proceedings:** We may have to disclose your medical information if we receive a subpoena from a judge or administrative tribunal.
- **Law Enforcement:** We may have to disclose your medical information in conjunction with a criminal investigation by a Federal or State law enforcement agency.
- **Serious Threats to Health or Safety:** We may be required to disclose your medical information if, in our opinion, doing so will help avert a serious threat to the public.
- **Military Personnel:** We may disclose your medical information to the appropriate command authorities.
- **Worker's Compensation:** We may disclose your medical information to comply with laws regarding worker's compensation.

Patient Rights:

You have certain rights with respect to your medical information.

Requesting Restrictions: You may ask us to limit our use or disclosure of your protected health information. We are not required to agree to your request, but if we agree to it, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. Your request must: 1) be in writing, 2) describe the information that you want restricted, 3) state if the restriction is to limit our use or disclosure, and 4) state to whom the restriction applies. You may revoke your restriction at any time by contacting our Privacy Coordinator as noted on the first page. We may ask to reschedule your exam while we consider your request.

Confidential Communications: You may ask that we communicate with you in a particular way, or at a certain location, to maintain your confidentiality. Your request must be in writing, tell us how you intend to satisfy your financial responsibility, and specify an alternate way that we can contact you confidentially. You do not have to give a reason for your request. In certain circumstances, we may require payment in full at the time you have your exam. You may revoke your request at any time by contacting our Privacy Coordinator as noted on the first page. We may ask to reschedule your exam while we consider your request.

Inspect and Copy: You may request access to inspect and copy your medical information maintained in our records, including medical and billing records. Your request must be in writing and you may request your original mammograms. We will act on your request for copies within 30 days after we receive it or within 60 days if the information is stored at another location. For patients in New York, we will act on your request to inspect your records within 10 days of receipt of the request. If we must deny your request, we will send you a written denial. If this happens, you may request a review of the denial. We may charge you a fee for providing copies. If that is the case, we will advise you of the cost of those copies at the time that we arrange for you to pick them up or have them delivered to you. We will compute these fees based on the state guidelines. You may also have to pay for the cost of postage or shipping, depending on how you ask that we get these copies to you. We may not be able to deny your request based on your inability to pay for them.

Amendment: You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if we believe that the information is complete and accurate, if the information is not part of the medical information that you would be permitted to inspect or copy, or if we did not create that information. You may also write a brief statement about the accuracy of our records and ask that we make it part of the medical record.

Accounting of Disclosures: You may request a list of non-routine disclosures that we have made of your medical information over the past 6 years. This does not include disclosures that we make for your treatment, to seek payment for our services, or for normal business operations as noted in the section on permitted uses and disclosures, or for those you authorize in writing. Your first request within a 12 month period is free, but we may charge for additional lists within the same 12 month period.

Paper Copy of this Notice: You are entitled to receive a paper copy of our Notice of Privacy Practices by contacting our Privacy Coordinator using the contact information on the first page.

File a Complaint: If you believe that we have violated your privacy rights, you may file a complaint directly with our Privacy Coordinator using the information on the first page. You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not penalize you for complaining.

Patient Authorizations for Certain Disclosures:

We will request your written authorization for uses and disclosures of your medical information that we did not identify in this notice or for those not otherwise permitted by law. These disclosures include your requests to provide exam results to your attorney, for exams related to life insurance or disability insurance applications, or for pre-employment physicals, among others. You may revoke your authorization in writing at any time by contacting our Privacy Coordinator using the contact information on the first page.



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ACKNOWLEDGMENT – RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge receipt of the provider's Notice of Privacy Practices.

Signature of Patient or Personal Representative

____/____/____
Date

FOR INTERNAL USE ONLY

- I presented the patient or personal representative with the Notice of Privacy Practices, but the patient or personal representative refused to sign the acknowledgement.

Signature of Imaging Center personnel

____/____/____
Date