LEGACY HEART CARE

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize, Legacy Heart Care of Fort Worth, LLC, to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Information to be used or disclosed:

- ☐ Progress Notes
- ☐ Medication Sheet
- ☐ EKG
- ☐ Echocardiogram
- ☐ Stress Test
- ☐ Cardiac Catheterization
- ☐ Operative Reports
- ☐ History & Physical
- ☐ Admission Summary
- ☐ Discharge Summary
- ☐ Laboratory Tests
- ☐ Other _____

Persons Authorized to use or disclose information:

- ☐ Cardiologist: _____
- ☐ Primary Care Physician: _____
- ☐ Other: _____

Persons to whom information may be disclosed:

Legacy Heart Care of Fort Worth, LLC
2500 West Freeway, Ste 200
(817) 423-4400 Phone (817) 423-8080 Fax

Expiration Date of Authorization

This authorization is valid for one year after the date you sign it unless you enter a different date or expiration here:_____, unless revoked or terminated by the patient or their personal representatives.

Right to Terminate or Revoke Authorization

To revoke or terminate this authorization submit a written revocation to Legacy Heart Care of Fort Worth, LLC.

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient Birth Date

LEGACY HEART CARE

Medical Information Release Form

Name: _____

Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until **terminated by me in writing**.

Messages

Please call: [ ] my home _____

[ ] my work _____

[ ] my cell _____

If unable to reach me:

[ ] you can leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

LEGACY HEART CARE

Appointment of Representative

Provider Name: Legacy Heart Care of Fort Worth, LLC.

2500 West Freeway, Ste 200 Fort Worth, TX 76102

Provider Tax ID: 26-3015033

Provider NPI: 1730120908

Appointment of Representative: I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated above.

Patient Name: _____ Member ID: _____

Address: _____ City, State, Zip: _____

Phone: _____

_____ _____

Signature of Party Seeking Representation (patient) Date

Acceptance of Representative: I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative and that I recognize that any fee may be subject to review and approval by the Secretary.

_____ _____

Signature of Appointed Representative Date

_____ _____

Printed Name Title

_____ _____

Phone Fax

LEGACY HEART CARE

Notice of Privacy Practices Acknowledgement
(HIPAA)

Patient Name:_____ Date of Birth: _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how our health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations.

☐ I have received the Notice of Privacy Practices

_____ _____
Patient's (or Legal Representative) Signature Date

_____
Relationship of Legal Representative

Office Use Only

To be completed only if acknowledgement is not signed.

1. Does Patient have a copy of the Privacy Notice? ❑ Yes or ❑ No

2. If answered "No" above, please explain why the patient did not sign the acknowledgement form and Legacy Heart Care of Fort Worth, LLC efforts in trying to obtain the patients signature:

   - ❑ Individual or Personal Representative chose not to sign
   - ❑ Individual or Personal Representative did not respond after more than **one** attempt
   - ❑ Patient Unable to Comprehend
   - ❑ Patient Communication Barrier
   - ❑ Other:_____

Completed by:

_____ _____
Legacy Heart Care of Fort Worth, LLC Representative Date

LEGACY HEART CARE

Attendance and Conduct Policy

The Purpose of this policy is to ensure adequate compliance, optimal clinical outcomes and a safe professional treatment environment. It is our goal at Legacy Heart Care of Fort Worth, LLC to achieve clinical excellence above the minimum standard of care while providing a pleasant experience.

- ***Attendance***

Legacy Heart Care fully understands that at times it might be difficult to make your pre-arranged treatment time. We will gladly reschedule your treatment time to any available opening in the schedule to accommodate your personal needs. It is our firm belief that achieving an attendance rate of 80% is not only reasonable but is vital to promote adequate clinical progress. In the event an individual's attendance rate drops below the 80%, and there are patients waiting for treatment due to a full treatment schedule, that individual may be subject to a treatment stoppage so that others may begin treatment without an unnecessary delay in care. This policy will be reviewed on a case by case basis for its appropriate implementation and to consider each individual circumstance affecting their attendance.

- ***Conduct***

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Legacy Heart Care expects team members, visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights and safety of others. Disruptive behavior can include attempting to intimidate, harass or make derogatory comments of an offensive or sexual nature. This can include physical and non-physical, verbal or gestures.

Signing this document certifies that you understand the clinical efficacy of Enhanced External Counterpulsation (EECP) is driven by patient attendance, and Legacy Heart Care conduct policy; and agree to its enforcement in the event it becomes appropriate. If you have any questions or concerns, please do not hesitate to speak with a Legacy Representative.

_____ _____

Printed Patient Name Date of Birth

_____ _____

Signature Patient Date

_____ _____

Legacy Heart Care of Fort Worth, LLC Representative Date