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| **PATIENT INFORMATION** |

\_\_\_Dr. \_\_\_Mr. \_\_\_Mrs. \_\_\_Miss \_\_\_Jr. \_\_\_Sr. \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Male \_\_\_Female

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_

Name(Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Numbers: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who OTHER than yourself can we talk to if you are unavailable?

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PRIMARY INSURANCE** |

Insurance Company/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Social Security No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscribers Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Male \_\_\_Female Copay Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is a Referral Required:\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECONDARY INSURANCE** |

Insurance Company/Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Social Security No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscribers Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Male \_\_\_Female Copay Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is a Referral Required:\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PHARMACY INFORMATION** |

Pharmacy Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*I consent to electronic transmitting of prescriptions to and/or from my pharmacy over a secure pathway.\*\*

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PRIMARY CARE PHYSICIAN** |

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

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PATIENT CONSENT** |

I, the undersigned, hereby consent to and authorize the following:

* the administration and performance of all treatments
* the administration of any needed anesthetics
* the performance of such procedures as may be deemed necessary of advisable in the treatment of this patient
* the use of prescribed medications
* the performance of diagnostic procedures/tests and cultures
* the performance of other medically necessary accepted laboratory tests that may be considered physician or their assigned designees

I fully understand that this consent is given in advance of any specific diagnosis or treatment and I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing. I understand that Dominion Cardiovascular Specialists, LLC may include consent at satellite offices under my common knowledge.

I, the undersigned, authorized Dominion Cardiovascular Specialists, LLC to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

Medicare Patients: I authorize PROVIDER to release medical information about me to Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Dominion Cardiovascular Specialists, LLC

I hereby authorize Dominion Cardiovascular Specialists, LLC (PROVIDER) to release medical information to any healthcare provider or third-party insurance company for the purpose of treatment, payment, or operations, which may pertain to my care. I hereby authorize payment directly to PROVIDER of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by any third party carrier and in accordance with contractual terms and participatory agreements. Further, I acknowledge that I am indebted for past due charges, and I understand that I am financially responsible for those charges also. Should this account become delinquent, I agree to pay a collection fee not to exceed 33 1/3% of the balance then outstanding in addition to any court costs and or including attorney fees.

I have reviewed and understand my patient rights and responsibilities. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **POLICIES AND PROCEDURES** |

Dominion Cardiovascular Specialists, LLC is dedicated to making your experience here a good one. Please Initial the following policies we have in place in order for us to concentrate on giving you the best care possible:

\_\_\_We require 24 hour notice for cancellations so we may accommodate other patients that may require our services. This will assist us in meeting the medical needs of the community that may require immediate attention. Failure to give a 24 hour notice will result in a $25.00 fee for missed established patient, and follow up appointments, and $100.00 fee will be assessed for all missed procedure appointments.

\_\_\_If a referral is required for your office visit, it is the patient’s responsibility to obtain this from their primary care physician. Failure to obtain a referral could result in payment denial from the insurance company and would result in becoming the patient’s responsibility.

\_\_\_If you need a prescription to be filled we will be happy to write it for you. However, please allow 24-48 hours for refill requests.

\_\_\_It is the responsibility of the patient or guarantor to ensure that Dominion Cardiovascular Specialists, LLC has the correct insurance information on file. Failure of payment from your insurance company will result in patient billing and responsibility.

\_\_\_I have received the Notice of Privacy Practices and I have been provided with opportunity to review it.

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| **MEDICATIONS** |

**PLEASE LIST ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS THAT YOU ARE CURRENTLY TAKING.**

**PLEASE BRING A CURRENT MEDICATION LIST WITH YOU TO EVERY APPOINTMENT!**

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| **MEDICATION NAME** | **STRENGTH (Ex: 4mg)** | **DOSAGE (Ex: ONCE DAILY)** | **REASON** | **LENGTH OF TIME ON MEDICATION** |
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| **MEDICAL HISTORY** |

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| **CONDITION** | **DATE (YEAR)** | **PROCEDURE/TREATMENT** | **HOSPITAL NAME** |
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| **ALLERGIES** |

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| **FAMILY HISTORY** |

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| **RELATIONSHIP** | **CONDITION(S)** | **CURRENT AGE** |
| **FATHER** |  |  |
| **MOTHER** |  |  |
| **BROTHER** |  |  |
| **SISTER** |  |  |
| **OTHER** |  |  |
| **OTHER** |  |  |

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| **CARDIAC HISTORY** |

Have you ever been diagnosed with any heart condition? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a heart attack? \_\_\_Yes \_\_\_No If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had heart surgery? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a heart Catherization? \_\_\_Yes \_\_\_No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received a blood transfusion? \_\_\_Yes \_\_\_No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had ulcers or other gastric bleeding? \_\_\_Yes \_\_\_No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SOCIAL HISTORY** |

Who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children? \_\_\_\_\_\_\_\_\_\_\_\_ How many? \_\_\_\_\_\_\_\_\_\_\_\_

Are you a smoker? \_\_\_Yes \_\_\_No If Yes, how many packs per day? \_\_\_\_\_\_\_ How long have you smoked? \_\_\_\_\_\_\_\_

Do you have any serious intentions to quit? \_\_\_Yes \_\_\_No

If you have already quit, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in your household smoke? \_\_\_Yes \_\_\_No

Do you drink alcohol? \_\_\_Yes \_\_\_No What type of alcohol? \_\_\_\_Beer \_\_\_Wine \_\_\_Hard Liquor \_\_\_Mixed Drinks

How often do you drink? \_\_\_\_\_\_\_\_\_\_\_\_ Do you consume caffeine? \_\_\_Yes \_\_\_No If yes, how much? \_\_\_\_\_\_\_\_

Do you or have you ever used illegal drugs? \_\_\_Yes \_\_\_No If yes, when and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEMALES ONLY:

Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you breast feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_

If you have been pregnant, how many times? (include all pregnancies)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of live births \_\_\_\_\_\_\_\_\_\_

Date of last period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Menopause onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What brings you in our office today?

* Chest pain
* Shortness of breath
* Palpitations
* Dizziness
* Passing out
* Swelling of the hands/feet/ankles/legs
* Irregular heartbeats
* Family history of heart problems

909 Hioaks Road, Suite E, Richmond, VA 23225

Phone: (804) 269-5112

Fax: 877-795-7329

**MEDICAL RECORDS REQUEST**

**To be completed by Staff:**

**Release From:**

Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION REQUESTED**

**[ ] ALL MEDICAL RECORDS [ ] MOST RECENT LABS [ ] OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RETURN TO:**

Dominion Cardiovascular Specialists, LLC Office Fax: 804-269-0562

**To be filled out by Patient- Please sign and date \*\*DO NOT sign as witness\*\***

**Patient Information:**

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

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **NOTICE OF PRIVACY PRACTICE** |

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW CAREFULLY.

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health care professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage, such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations: Your health information may be used as necessity to support the day-to-day activities and management of Dominion Cardiovascular Specialists, LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state’s public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

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| **INDIVIDUAL RIGHTS** |

You have certain rights under the federal privacy standards. These include:

* the right to request restrictions on the use and disclosure of your protected health information
* the right to receive confidential communications concerning your medical condition and treatment
* the right to inspect and copy your protected health information
* the right to amend or submit corrections to your protected health information
* the right to receive an accounting of how and to how your protected health information has been disclosed
* the right to receive a printed copy of this notice

Our duties: We are required by law to maintain the privacy of your protected health information and provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise Privacy Policies: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may require by the changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to inspect protected health information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the attention Privacy Officer, Dominion Cardiovascular Specialists, LLC. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint.