# GEM STATE RADIOLOGY
doing business as
# ADVANCED VEIN THERAPY

## MEDICAL IDENTITY VERIFICATION
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## ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Patient Name: ___________________________________________________________________

Medical identity is that unique set of information that makes up the identity of an individual and may also be referred to as Protected Health Information (PHI) as per HIPAA laws and regulations. Medical identity theft is theft that occurs when someone uses an individual's name or other parts of the individual's identity – such as insurance information or a Social Security Number – *to obtain medical services or goods without the victim's knowledge.* Medical identity theft can also occur when someone uses the person's identity to obtain money by falsifying claims for medical services and falsifying medical records to support those claims. The essence of the crime is the use of a medical identity by a criminal and the lack of knowledge by the victim.

In an effort to further protect patients being treated at Advanced Vein Therapy (AVT) from medical identity theft we must view and copy your non-expired, government issued photo identification (ID) such as a driver's license, passport, or other government issued photo ID. In the event you do not have a government issued photo ID then additional identifying documents will be requested to confirm identity.

Furthermore, I have been offered a copy of GSR'S "Notice of Privacy Practices" that describes in detail how my Protected Health Information (PHI) gathered may be used or disclosed by GSR/AVT per HIPAA Privacy regulations and further describes my rights under HIPAA. **Please choose one option below:**

**O** I have been offered a copy of the Notice of Privacy Practice and acknowledge I have received a copy.

**O** I have been offered a copy of the Notice of Privacy Practice and am DECLINING to accept a copy.

I have read this document and understand the intention of AVT's effort to protect my identity from theft by verifiable identification and have been offered a copy of the "Notice of Privacy Practices".

______________________________________________ ____________________
Signature of Patient Date

______________________________________________ ____________________
Printed Name of Authorized Representative Date

__________________________________________ ________________________
Signature of Authorized Representative Describe Authority to act on behalf of Patient.

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**OFFICE USE ONLY:**

Describe identification presented: ____________________________________________

Confirmed by AVT Employee: ____________________________ ______________
Print Name Initials

**O** Patient/Authorized Representative allowed VISUAL INSPECTION ONLY of identification document(s) presented**.**

**O** Patient or Authorized Representative refused to sign this Acknowledgement

Originated: HIPAA Acknowledgment Version 1.0 April 2003; Revised: May 2009; November 2012
Originated: Medical Identity Theft/HIPAA Acknowledgement May 2009; Revised Aug 2009, Mar 2011