BENEFIT ASSIGNMENT/CONSENT/PRIVACY AND HIPPA POLICY

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private, HMO/PPO and commercial insurances as well as third party payers to ADVANCED SURGICAL ASSOCIATES, LLC. A photocopy of this assignment fu to be considered as valid as the original. I understand that I am financially responsible or charges not covered by my insurance plan including both Medicare and/or Medicaid (title XIX or Title XX benefits).

ADMINISTRATIVE AND FINANCIAL POLICIES

We are committed to providing you with the best care and are pleased to discuss our professional fees with you at any time. Your understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, financial policy or your responsibility.

1. All patients must complete the New Patient Information Form prior to being seen by the physician. You will be asked to update this information periodically. Failure to provide necessary information may require that your appointment be rescheduled or cancelled.
2. You must present your insurance card each time you are seen in our office. If you do not have your insurance card on the initial visit, we will reschedule your appointment. A picture ID is also required.
3. **All Fees are due and payable at the time of your appointment.** If we are contracted with. your insurance carrier, you will be responsible for the co-pay at the time of service. You will be billed for any remainder (patient responsibility) after we have received a response from your insurance carrier.
4. A PO Box address is not acceptable on our patient information sheet. We ***must*** have a physical address.
5. Your Social Security number must be on our patient information sheet.
6. We charge $30.00 for each FMLA, disability or insurance form that pays you or gives you permission to be relieve temporarily from your employment. This charge also extends to the faxing of records or the writing of a letter to the above mentioned.
7. There is a $30.00 return check charge on all returned checks.
8. It is your responsibility to know what hospitals and facilities participate with your health insurance plan.
9. All inactive patient records are destroyed after (7) seven years.
10. We will reserve the right to charge a $50.00 No Show Fee in the event you do not cancel your appointment within 24 hours of your scheduled appointment.

PRIVACY RULE

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable predications to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing, under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI.

You may not revoke actions that have already been taken which relied on this or a previously signed consent If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. You may review Advanced Surgical Associates, LLC's notice of privacy practices on their website or you can ask for a copy at the time of your office visit. The signing of the consent form verifies that you have received the '"Notice of Privacy Practices" information pamphlet as mandated by the Health Insurance Portability Act of 1996(HIPPA) and have been given the opportunity to review it.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for ADVANCED SURGICAL ASSOCIATES, LLC. to furnish medical care and treatment to (patient/guardian) *_____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

CONSENT TO LEAVE A MESSAGE

Advanced Surgical Associates, LLC, in compliance with HIPAA guidelines, is very concerned with your privacy in relationship

with your medical care. Please specify person(s) with whom we may discuss your personal health information. (Check all that apply):

ALL RELATED MEDICAL CONDITIONS AND/OR TEST RESULTS MAY BE DISCUSSED WITH THE FOLLOWING INDIVIDUALS:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

****Is it permissible to send you a text or email with appointment reminders/confirmations? ☐YES ☐NO**

****Is it permissible to leave you a voicemail message that may include test or lab results? ☐YES ☐NO**

RELEASE OF INFORMATION

I hereby authorize said assignee to release all medical information necessary, including Medical Records, to any carrier listed on my patient information for the purposed of processing any insurance or workman's compensation claim to secure payment. I also authorized release of information to any hospital/facility, ancillary provider or physician I may be referred to by this office.

*Patient Signature: _____ Date: _____