Please PRINT the Following Information: Date: _____

Patient Name: _____
First Middle Last

Social Security #: _____ Age:_____ Sex:_____ DOB: _____

Address: _____ City: _____

State/ Zip: _____ Home Phone: _____ Cell Phone: _____ Email: _____

REASON FOR VISIT: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Please indicate below what categories you may fall under. (You do have an option to defer).

Ethnicity: ◯ White ◯ Black/African American ◯ Asian ◯ American Indian/Alaskan Native ◯ Other ◯ Defer

Race: ◯ Hispanic/Latino ◯ Non-Hispanic ◯ Native Hawaiian/Other Pacific Islander ◯ Defer ◯ Other

Preferred Language: ◯ English ◯ Spanish ◯ Chinese ◯ French ◯ German ◯ Russian ◯ Japanese ◯ Italian ◯ Defer

PREFERRED PHARMACY: _____ Pharmacy Number: _____

Address: _____ Pharmacy Fax Number: _____

EMPLOYER: _____ Occupation: _____

Employer Address: _____

Insurance Subscriber: _____

Individual Responsible for the Bill: _____

Relationship: _____ Social Security #: _____ DOB: _____

Address: _____

IN CASE OF EMERGENCY, NOTIFY: _____

Relationship: _____ Phone: _____

Address: _____

I authorize Park Surgical Specialists to bill my insurance company for charges incurred during the course of treatment and to provide any medical information necessary to process insurance claims. I authorize payment to be made directly to Park Surgical Specialists and a copy may be used instead of the original. I authorize my doctor to inquire about my account and to receive any information that may be necessary. I understand that Park Surgical Specialists will file any claims with my insurance company for charges incurred**. However, if my insurance company does not have a contract with Park Surgical Specialists, I UNDERSTAND THAT I WILL BE PAYING FOR MY VISIT IN FULL.** If my insurance company does have a contract with Park Surgical Specialists, I agree that I will be responsible for all non-covered services and pre-existing conditions. I will be responsible for any co-payments and deductibles.

Patient's Signature: _____ Date: _____

Guarantor's Signature (if patient is a minor): _____

MEDICARE SECONDAY PAYER QUESTIONNAIRE

There may be situations where Medicare is not your primary payer or Medicare coverage policies vary. Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer.

This Questionnaire must be completed by any patient who may be eligible for Medicare as primary or secondary.

If Medicare has been replaced by another plan, Section II will need to be completed.

We appreciate your help by completing this questionnaire.

Patient Name: _____ Account Number: _____

Section I:

Are you currently receiving any Home Health Services (including nursing, bathing or dressing assistance, Injections or respiratory services?)	**YES**	**NO**
Are you covered under a Medicare Pat C (Medicare Advantage/Medicare +Choice) If YES, enter the name of the health plan: _____	**YES**	**NO**
Was your illness or injury due to a **work-related** accident or condition? If YES, enter the date of illness or injury: _____ Provide the name of your employer on the Patient Registration Form.	**YES**	**NO**
Was your illness or injury due to a non-work-related accident? If YES, enter the date of illness or injury: _____ If no-fault, auto, or liability insurance is available, enter information in Section II.	**YES**	**NO**
If you are entitled to Medicare based upon Age or Disability, are you currently employed? If YES, provide your employer's information on the Patient Registration form. If NO, enter your retirement date: _____	**YES**	**NO**
Do you have a spouse who is currently employed? If YES, provide your spouse's employer's information on the Patient Registration form. If NO, enter your spouse's retirement date: _____	**YES**	**NO**
Do you have group health plan coverage based upon your own or your spouse's employment? If YES, enter your and/or your spouse's group health plan information in Section II.	**YES**	**NO**
Are you entitled to Medicare due to the kidney transplant? ◯No Transplant ◯ No Dialysis If YES, enter date that dialysis began:	**YES**	**NO**
Are you receiving Black Lung (BL) Benefits? If YES, enter date benefits began: _____	**YES**	**NO**

Section II (Please provide us with your insurance card)

Type of Insurance Coverage: ◯ Workers Compensation ◯ No-fault/Auto/Liability ◯ Group Health Plan

Name of Policy Holder: _____ Insurance Name:_____

Street Address: _____

City: _____ State/Zip: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

If Group Health Plan, approximate number of employees: ◯ 1-19 ◯ 20-99 ◯ 100 +

I certify that all the information provided herein is true can correct.

_____ _____

Signature of Patient/ Representative Date

Important Information For New Patients

Park Surgical Specialists policy requires all healthcare staff to obtain, verify, and record information that identifies each new patient.

This policy is for your protection. Identity thieves use people's identifying information to request health care services. This misuse of your information may result in declined healthcare coverage or financial responsibility for services not rendered to you.

What This Means For You:
When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. We may request that you allow us to take a digital photo of you for our records and your protection.

Park Surgical Specialists will obtain, verify, and record the following information on new patients.

◯ Name
◯ Address
◯ Driver's License # and State
◯ Other Photo ID
◯ Date of Birth
◯ Social Security/ TIN
◯ Insurance ID
◯ Other Supporting documentation if needed

If identification is not possible during an emergency situation, you will not be denied medical care. It will be the responsibility of the patient to provide Park Surgical Specialists appropriate identification as required by our Policy.

I certify I am who I claim to be. I have provided documentation supporting claims and my information was verified by Park Surgical Specialists. It will be my responsibility to inform Park Surgical Specialists of any changes in my personal information upon future visits.

_____ _____
Patient's Signature Date

For Internal Office Use Only

I have followed Park Surgical Specialists Policy in obtaining, verifying, and recording this patient's identification.

_____ _____
Staff Signature Date

PATIENT ACKNOWLEDGEMENT RECEIPT OF NOPP, FINANCIAL POLICY, PATIENT RIGHTS & ADMINISTRATIVE FEES

I have been offered a copy of the following Park Surgical Specialists policies:

- ◯ Notice of Privacy Practices
- ◯ Financial Policy
- ◯ Patient Rights & Responsibilities
- ◯ Administrative Fees

By signing below, I acknowledge that I have read and have been offered all of the policies listed above for Park Surgical Specialists.

_____

Signature of Patient or Representative

_____

Printed Name

_____

Relationship of Representative to Patient

_____

Description of Representative's authority to act on behalf of Patient

_____

Date

Authorization for Release of Information

Please check the appropriate boxes below as they apply to our ability to communicate Protected Healthcare Information with you and/or family members/ others regarding your appointments, results, financial information and any other medical information pertaining to the care you received by Park Surgical Specialists.

If you do not check any of the boxes, we cannot leave a message, e-mail, or discuss with anyone the information pertaining to your care. This would include your appointments, results, financial information and any other medical information pertaining to the care you received by Park Surgical Specialists.

ALCOHOL/ DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 1. Release of such records requires specific consent. I hereby grant such specific consent as checked below. **I UNDERSTAND** that the following record are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

Patient Name: _____ Date: _____

Park Surgical Specialists is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Circumstances may arise where obtaining a signed release may be difficult. As the patient, you do have an option to allow Verbal Authorization for Release of Information for you and those parties you listed below. If you will permit verbal authorizations, please acknowledge who and what you want disclosed below.

Patient Name: _____ Date: _____

Person/Entity to Receive Information

Check each the mode communication and the person/ entity that you approve to receive information.

- ◯ Live Phone Conversation
- ◯ Voice Mail
- ◯ Secure E-Mail
- ◯ Mail or Courier
- ◯ Fax

Other: _____

- ◯ Spouse/Significant Other
  Provide name: _____
- ◯ Parent/Family Member
  Provide name: _____
- ◯ Other Entity
  Provide name: _____

Description of Information to Be Released

Check each item that can be given to each person/entity on the left of this section.

- ◯ All Records
- ◯ Test Results-Labs, Pathology, Diagnostics, X-Ray
- ◯ Consultation Note, History & Physical Notes
- ◯ Encounter Forms
- ◯ Mental Health Information
- ◯ Alcohol/Substance Abuse Treatment
- ◯ HIV/Aids Information
- ◯ STD Information
- ◯ Demographics
- ◯ Financial Information
- ◯ Other:

_____

Patient Information:

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I release Park Surgical Specialists from any and all legal liability that may arise from the release of this information to the party named above. I understand that I have the right to refuse this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until I revoke it. If I decide to revoke it, I will submit a revocation in writing. This form will be valid with no expiration unless a shorter time period is listed below. If you leave the second date blank this will be an ongoing authorization. My authorization is valid from the dates below.

_____ TO _____

MM/DD/YY MM/DD/YY

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (Attach necessary documentation).

Patient Name: _____

PAST MEDICAL HISTORY

Please check the circle if you have ever been treated for:

◯ HIV/AIDS ◯ Diabetes ◯ Kidney disease ◯ Transfusion reaction
◯ Thyroid disease ◯ Liver disease ◯ Sickle cell disease ◯ High blood pressure
◯ Lung disease ◯ Cancer ◯ Heart disease ◯ Glaucoma

Musculoskeletal:

◯ Back/Neck pain ◯ Leg cramping ◯ Arthritis ◯ Cane, walker, crutches ◯ Artificial arm/leg ◯ Muscles weak

Skin:

◯ Current bruises, rash ◯ Current wounds, sores, ulcers ◯ Problems with tape ◯ Current burns

Cardiovascular:

◯ Heart attack ◯ Pacemaker ◯ Blood clots, phlebitis
◯ Chest pain, angina ◯ Murmur ◯ Free bleeder
◯ Irregular pulse ◯ Rheumatic fever ◯ Hemophilia
◯ Cardiac arrest ◯ Mitral valve prolapse ◯ Bruise easily
◯ Congestive heart failure ◯ Anemia ◯ Circulation problems

Respiratory:

◯ Bronchitis ◯ Emphysema, COPD ◯ Home oxygen therapy ◯ Chronic cough
◯ Pneumonia ◯ Tracheostomy ◯ Asthma, wheezing ◯ Shortness of breath
◯ Sleep apnea ◯Collapsed lung ◯ Sinus problems ◯ Tuberculosis (TB)

Neurological:

◯ Seizures ◯ Stroke ◯ Migraine headaches ◯ Paralysis
◯ Spinal cord injury ◯ Fainting ◯ Head injury ◯ Numbness or tingling

Gastrointestinal:

◯ Hiatal hernia, reflux, heartburn ◯ Abdominal pain ◯ Gall bladder problems ◯Hepatitis
◯ Liver disease ◯Low blood sugar ◯ Bowel disease ◯ Peptic ulcer
◯ Diet, food intolerance ◯ Swallowing problems ◯ Recent weigh gain/loss ◯ Hemorrhoids
◯ Recent vomiting or diarrhea ◯Loss of Appetite ◯ Constipation ◯ Ostomy

Genitourinary:

◯ Kidney stones ◯ Frequent urine infections ◯ Dialysis ◯Difficulty with control
◯ Difficulty with urination ◯ Prostate disease ◯ Blood in urine ◯ Sexual problems

Breast:

◯ Breast cancer ◯ Benign breast disease

(For Breast patients only)

◯ Last menstrual period _____/_____/_____ (Date) ◯ History of hormone replacement therapy
◯ Age when your 1st child was born _____ years old ◯ Previous breast biopsy
◯ Atypical ductal/lobular hyperplasia ◯ Age of menarche _____ years old
◯ Number of pregnancies _____ ◯ Number of live births _____

Other: _____

Patient Name: _____

REVIEW OF SYSTEMS

General:

◯ Fever/Chills ◯ Weight loss

Eyes/Ears/Nose/Mouth:

◯ Vision Loss ◯ Difficulty Swallowing ◯ Nosebleeds
◯ Hoarseness/ Voice Change ◯ Hearing Loss ◯ Ringing in the Ears

Cardiovascular:

◯ Chest pain ◯ Heart failure ◯ Shortness of Breath
◯ Fainting Spells ◯ Irregular Heartbeat ◯ Swollen ankles

Endocrine:

◯ Diabetes ◯ Thyroid Disease/Goiter

Respiratory:

◯ Wheezing ◯ Chronic Bronchitis ◯ Chronic Cough ◯ Asthma ◯ Emphysema

Gastrointestinal:

◯ Abdominal Pain ◯ Nausea/Vomiting ◯ Bloody Stools ◯ Diarrhea
◯ Black Tarry Stools ◯ Constipation ◯ Indigestion

Musculoskeletal:

◯ Arthritis ◯ Joint Pain

Integumentary:

◯ Rashes ◯ Pruritus ◯Hives

Neurological:

◯ Muscle Weakness ◯ Numbness/ Tingling ◯ Sensation

Psychiatric:

◯ Depression ◯ Nervous Breakdown

Genitourinary:

◯ Kidney Infection ◯ Blood in Urine ◯ Frequent Overnight Urination

Hematological/Lymphatic:

◯ Blood Transfusions/ ◯ Easy Bruising
◯ Anemia ◯ Bleeds Easily/ Hemophilia Reactions

Patient Name: _____

PATIENT ALLERGIES

ALLERGIES	SEVERITY	DATE	COMMENTS

FAMILY MEDICAL HISTORY

FAMILY HISTORY	RELATION	FAMILY HISTORY	RELATION
Anemia		High Cholesterol (Hyperlipidemia)	
Anesthesia Problems		Kidney Disease	
Bleeding Problems		Stroke	
Cancer		Liver Disease	
Diabetes		Autoimmune Disease	
Heart Disease		Blood Clotting Disorder	
High Blood Pressure		Lung Disease	

HOSPITALIZATION / SURGERIES

SURGERY / PROCEDURE	HOSPITAL	DATE	COMMENT

Smoking Status:

◯ Current Every Day Smoker (1) ◯ Never smoker (4) ◯ Heavy Tobacco Smoker

◯ Current Some Day Smoker (2) ◯ Smoker, current status unknown (5) ◯ Light tobacco smoker

◯ Former Smoker (3) ◯ Unknown if ever smoked

If YES, # Packs/day: _____ Number of Years: _____ Quit Date: _____/_____/_____

Patient Name: _____

Alcohol Use Status:

◯ Does not drink ◯ Currently Drinks ◯ Did not ask ◯ Quit ◯ Former Drinker

If YES, Alcohol Type: _____ Drinks/Week: _____ Quit Date: _____/_____/_____

Illicit/Illegal Drug Status:

◯ Does not take drugs ◯ Currently takes drugs ◯ Did not ask ◯ Quit ◯ Former Drug User

If YES, Drug Type: _____ Quit Date: _____/_____/_____

Injury Information

Type of Injury:

◯ Work ◯ Sports ◯ Auto ◯ Other ◯ None

If YES, Injury Date: _____/_____/_____

Injury Details:

_____

_____

CURRENT MEDICATIONS

DRUG NAME	DOSAGE	FREQUENCY	PRESCRIPTION DATE	PRESCRIBED BY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Park Surgical Specialists, we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule and is effective March 23, 2013. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information
Each time you visit Park Surgical Specialists, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, your health insurer or an outside collection agency.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your PHI.

Understanding what is in your record and how your PHI is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health records are the physical property of Park Surgical Specialists, the information belongs to you.
You have the right to request to:

- Access, inspect and copy your health record. Park Surgical Specialists maintains an electronic medical record ("EMR"). You have the right to access your health record in a machine-readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity.
- Amend your health record which you believe is not correct or complete. Park Surgical Specialists is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for Park Surgical Specialists; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by Park Surgical Specialists, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain an accounting of disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and healthcare operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. Communications of your PHI by alternative means (e.g. e-mail) or at alternative locations (e.g. post-office box).
- Place a restriction to certain uses and disclosures of your information. In most cases Park Surgical Specialists is not required to agree to these additional restrictions, but if Park Surgical Specialists does, Park Surgical Specialists will abide by the agreement (except in certain circumstances were disclosure is required, or permitted, such as an emergency, for public health activities, or when disclosure is required by law). Park Surgical Specialists must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose PHI expect to the extend that action has already been taken.

Our Responsibilities

Park Surgical Specialists is required to:

- Maintain the privacy of your PHI.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect.
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.
- Notify you in writing of a breach where you unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured by technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your PHI without your written authorization, except at described in this Notice.

If you have questions and would like additional information or to report a problem, you may contact:

Park Surgical Specialists
4255 Johns Creek Parkway, Suite D
Suwanee, GA 30024

If you believe your privacy rights have been violated, you can file a written complaint with Park Surgical Specialists Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will not be retaliation for filing a complaint with either the Privacy Office or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, Park Surgical Specialists operates an Electronic Medical Records System. This is a system that stores Protected Healthcare Information about you.

Park Surgical Specialists may also provide a subsequent healthcare provider with PHI about you (e.g., copies of various reports) that should assist him or her in treating you in the future. Park Surgical Specialists may also disclose PHI about you to, and obtain your PHI from, electronic PHI networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to perform functions or activities on behalf of, or certain services for, Park Surgical Specialists that involve the use or disclosure of PHI and disclose your PHI to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail or in person regarding any items that assist Park Surgical Specialists in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location of any items that assist Park Surgical Specialists in carrying out Treatment, Payment, and Health Care Operations.

Communication with Family/ Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam-room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open Treatment Areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your PHI or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow they them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. Park Surgical Specialists may use a single authorization to combine conditional and unconditional authorizations for research (e.g., participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatments is conditioned on the provision of a written authorization) and unconditioned research components, and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

Coroners, Medical Examiners and Funeral Directors: In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment of your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at Park Surgical Specialists, to a business associate or a foundation related to Park Surgical Specialists so that they may contact you to raise money for Park Surgical Specialists. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of your PHI: Park Surgical Specialists may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the renumeration unless such an exchange meets a regulatory exception.

Health Oversite Activities: We may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with healthcare, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your PHI if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your PHI if we are required by law to do so.

NOTICE OF ADMINISTRATION FEES

Park Surgical Specialists charges administrative fees for the following forms:

Annual Fee	$75.00 (optional – waives all other fees for one year)
Disability Forms	$25.00 (per form)
Account history	$15.00 (per form)

Medical Records – Charges per Georgia Law:
GEORGIA STATE COPY LAW
SECTION 2: CODE SECTION 31-33-1
The party requesting the patient's records shall be responsible to the provider for the reasonable costs of copying and mailing the patient's record. The actual cost of postage incurred in mailing the requested records may also be charged, in addition, copying costs for a record which is in paper form shall not exceed $.97 per page for the first 20 pages of the patient's record which are copied. $.83 per page for pages 21 through 100 and $.66 for each page copied in excess of 100 pages. All the fees allowed by this code section may be adjusted annually in accordance with the medical component of the consumer price index. A charge of $25.88 may be collected for search retrieval and other direct administrative costs related to the request under this chapter.

Administrative Costs	$25.88 (e.g., search, retrieval and other labor costs)
Certifying the Copies	up to $9.70 per record
Cost of Postage	Actual Charges
First 20 pages of Patient's record	up to $.97 per page
Pages 21-100 of record	up to $.83 per page
Each page over 100 pages	up to $.66 per page

FINANCIAL POLICY

All Patients: **PARK SURGICAL SPECIALISTS DOES NOT ACCEPT MEDICAID.**
BY LAW, DEDUCTIBLES/ CO-PAYS CANNOT BE WAIVED.

- I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Park Surgical Specialists.
- Park Surgical Specialists accepts Cash, Checks, Money Orders, Visa, Master Card, Discover, and American Express.
- If my check is returned for non-payment due to insufficient funds or a closed account, Park Surgical Specialists will charge me a $25.00 fee. This fee is in addition to any fees that may be assessed by my bank for returned checks.
- If I do not speak English, it is my responsibility to obtain an interpreter to assist in completing and understanding these documents.
- In the event of default on this account with Park Surgical Specialists, this account will be submitted to an outside source of collections. Any unpaid balance will accrue 1.5% per month or 18% per year interest. If this account is collected by or through an attorney that is not our salaried employee, I will be liable for accrued interest, all costs of collection and 15% attorney's fees.

Uninsured Patients:

- If I do not have insurance, I am expected to pay for services rendered in advance unless prior arrangements are made.
- There is a 20% discount if balance is paid in full at time of service.

Surgical Patients:

- All procedures which are cancelled/rescheduled within 5 days of the surgery date will be charged a $150.00 non-refundable administration fee. (Unless cancelled by Physician).

Medicare Patients:

- Park Surgical Specialists participates in Medicare. Park Surgical Specialists will collect my 20% co-pay and any deductible at the time of service is rendered. If there is a Medigap/Supplemental policy in place, we will submit claims to both carriers.
- If I am a Medicare/ Medicaid patient, I am responsible for the balance Medicare does not pay.

Insured Patients:

- Park Surgical Specialists allow 60 days from the date a claim is filed for my insurance play to pay.

- **It is my responsibility to know and understand my insurance plan. This includes my financial responsibility for services rendered such as co-pays, deductibles, co-insurance and anything else that my insurance plan determines is my responsibility. We must collect Co-pays, deductibles and co-insurance per our contracts with insurance carriers. We cannot negotiate these amounts.**

- It is my responsibility to provide Park Surgical Specialist with any information necessary to process my claim. Any information requested by my insurance is necessary for processing. If I do not provide the requested information, I will be billed for the balance.

- I am required to provide Park Surgical Specialists with my most current insurance information. (This would include a copy of my current insurance card, any changes in insurance plan coverage, co-pay, deductible, co-insurance).

- I am responsible for any service and/or procedures not covered by my insurance plan. If I am seen without a referral, I am responsible for the charges. It is also my responsibility to ensure my insurance plan pays my bill in a timely manner. If no payment has been received after the sixty (60) day grace period, I will be billed for the balance.

- Park Surgical Specialists expects payment of my account in full within 30 days. If I cannot pay the entire balance, a payment plan can be arranged.

- It is my responsibility to inform Park Surgical Specialists of any changes in my contact information.

Managed Care Patients:

- I UNDERSTAND THAT I AM REQUIRED TO OBTAIN PROPER REFERRAL AND/OR AUTHORIZATION AS REQUIRED BY MY INSURANCE PLAN PRIOR TO MY APPOINTMENT WITH ANY OF THE PARK SURGICAL SPECIALISTS PHYSICIANS.

- IF AUTHORIZATION IS NOT OBTAINED FOR MY VISIT, MY INSURANCE PLAN MAY NOT PAY FOR MY TREATMENT. IN THIS CASE, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED. I UNDERSTAND THAT PARK SURGICAL IS NOT OBLIGATED TO SEE PATIENTS WITHOUT A VALID REFERRAL/AUTHORIZATION.

- CO-PAYMENTS/ DEDUCTIBLES WILL BE COLLECTED AT THE TIME SERVICES ARE RENDERED.

- I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to me directly to Park Surgical Specialists. I hereby authorize Park Surgical Specialists to release any information necessary to process my claim. I understand that I am legally and financially responsible for all charges not covered by my insurance plan. I hereby authorize payment directly to Park Surgical Specialists for payment on my account.

- I understand that if my insurance plan sends me a check for payment of the medical services provided by Park Surgical Specialists, the check belongs to Park Surgical Specialists and I must immediately deliver the check to Park Surgical Specialists for payment on my account.

- I understand and agree that I will be responsible for any co-pays, deductibles, and co-insurance amounts, as well as any services not covered by my insurance. After payment by my insurance plan and negotiated adjustments are made, any balance becomes my legal and financial responsibility.

- If my insurance plan denies my claim and I choose to appeal their decision, this form and my signature authorizes my physician at Park Surgical Specialists to submit an appeal along with any necessary medical information to my insurance plan.

PATIENT RIGHTS AND RESPONSIBILITIES

You Have a Right:

- To be treated with respect, consideration, and dignity always.
- To receive assistance in a responsible manner.
- To receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare. This information can be obtained by requesting physical copies or access to your secure electronic chart.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternatives and likely consequences of your decision.
- To express a complaint to the Office Manager, Physician, or staff.

You Have a Responsibility:

- To complete an Authorization for Release of Information Form.
- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of your insurance plan services and procedures for obtaining coverage. This includes knowing the referral policy for your plan, laboratory restrictions, and outpatient facilities covered by your plan as well as co-pay requirements.
- To always carry your insurance plan identification card and be prepared to show it at each office visit. Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered for the information provided is inaccurate.
- To treat all office personnel respectfully and courteously.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment. (24-hour notice).
- To pay all charges for co-payments, deductibles, non-covered benefits of services at the time of your visit unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternative and/or likely consequences if you refuse to comply.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.