Wilson Hand Surgery, PLLC
6560 Fannin Street
Scurlock Tower Suite 1810
Houston, Texas 77030-2747

HIPAA

New Patient Consent to the Use and Disclosure of Health Information

for Treatment, Payment, or Healthcare Operations.

I, _____, understand that as part of my health care, Barbara Wilson MD maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

A basis for planning my care and treatment,
A means of communication among many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill,
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have reviewed the *Notice of Health Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing the consent,
The right to object to the use of my heath information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
The right to request a copy of the *Notice of Health Information Practices* and this form.

I understand that Barbara Wilson MD is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Barbara Wilson MD reserves the right to change their notice and practices and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Barbara Wilson MD agree with their notice, they will send a copy of any revised notice to the address I have provided (whether by U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

By signing this agreement, I acknowledge that I fully understand and accept the terms of this consent.

_____ _____ _____

Patient or Personal Representative | Relationship to Patient | Date

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Consent for Medical Treatment

I hereby give my consent to Wilson Hand Surgery, PLLC and authorize her to provide my medical treatment. I understand that Wilson Hand Surgery, PLLC will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I understand, and knowing that I am suffering from a condition requiring medical care, I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by Dr. Barbara Wilson, her assistants or her consignees as may be necessary in her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination in the hospital. I authorize Wilson Hand Surgery, PLLC to perform any additional or different treatment that was not thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

_____	_____	_____
Patient Name	Patient Signature	Date

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Financial Policy Statement/ Contract

Wilson Hand Surgery, PLLC's (aka "WHS") policy is to bill the patient's insurance carrier as a courtesy. If there is another payer who may be responsible for the services rendered, it is the patient's responsibility to disclose that information **as soon as possible**, along with the payer's contact information, so the incorrect party is not billed. Third party payments such as personal injury settlements or general liability settlements must be paid directly to Wilson Hand Surgery.

The insured patient is responsible for any co-payments and/or deductibles that are due at the time service is rendered. Should there be a credit that is owed to the patient due to insurance adjustments, WHS will refund the excess back to the patient.

The above does not apply for patients that are covered by Worker's Compensation. However, the Worker's Compensation patient will be responsible for services rendered in the event their claim is denied/not covered.

If the patient does not have insurance, or the policy is expired, please express that to WHS before services are rendered to figure out available payment options.

Should the patient fail to make any payments for which they are responsible for in a timely manner, they are *also* responsible for all costs involving collecting monies owed, interest, incl. court costs, collection agency fees, attorney fees that are owed.

By signing below, I signify that I have read the above and understand my role and responsibility as a patient of Wilson Hand Surgery, PLLC. In the event that any insurance information changes or litigation is involved, I will notify WHS immediately.

I have read and I understand the entirety of this financial agreement. I have had a chance to ask questions. All my questions have been answered and I agree to the above financial agreement with WHS.

_____ _____ _____

Patient Name Patient Signature Date

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NEW POLICY STARTING: EFFECTIVE JANUARY 1ST, 2017

Facility: Wilson Hand Surgery, PLLC – Dr. Barbara Wilson, MD

Advanced Beneficiary Notice of Non-coverage (ABN)

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. Insurance may not pay for Durable goods listed below, so anything purchased from Wilson Hand Surgery will not be billed to your insurance.

EXAMPLES:

- **Splints. (hand, wrist, finger, and other)**
- **Cast supply (hand, wrist, finger, arm)**
- **All other supplies in office (including steroid medication)**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Durable goods listed above.

Durable Goods/ Supplies: Please choose **one**;

- o I want the durable goods listed above and I understand my insurance will not be billed. I will be responsible for the full payment; due at the time of purchase. I cannot appeal as my insurance will not be billed.
- o I don't want the durable goods listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Insurance will pay.

Medication(for injections): Please choose **one**;

- o I will buy the medicine from Wilson hand Surgery, PLLC and I understand my insurance will not be billed.
- o Please send the prescription to my pharmacy and I will pick it up before my appointment.

Signing below means that you have received and understand this notice. You may also receive a copy. (UPON REQUEST.)

_____ _____ _____

Patient Name Patient Signature Date

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NO SHOW/CANCELLATION POLICY

FOR SCHEDULED APPOINTMENTS & SURGERIES

We understand that there are times when a patient must miss an appointment due to emergencies or family/ work related obligations. There is administrative time that has been done on your behalf to assure that your insurance will cover your visit. The staff works to prepare for each clinic to prepare insurance verification, obtain records and prepare for the appointment. Other appts are not booked to hold time for your visit.

IN-OFFICE APPOINTMENTS:

- Due to cost to our time and business, there will be a $30 fee for all patient's that do not call to cancel their appointment **24 hours prior to a cancellation**. This fee will not be covered by insurance**.** One business day is needed for us to refill the appt that has been held.

SURGERIES:

- Due to a complex administrative time needed for surgery, there will be a $50 fee for all patient's that call to cancel their scheduled surgery.
- This fee will not be covered by insurance.

☐ **I UNDERSTAND THAT THERE IS A $30 CHARGE FOR NOT NOTIFYING WILSON HAND SURGERY OF A CANCELLATION 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT.**

☐ **I UNDERSTAND THAT I WILL BE CHARGED $50.00 IF I CANCEL MY SURGERY.**

_____ _____ _____

Patient Name Patient Signature Date

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Wilson Hand Surgery, PLLC

Designation of Personal Representatives

Under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) that became effective on April 14, 2003, health care providers and their staffs are limited in the information that they may share with individuals other than the patient or his/her parent or guardian. In many cases, patients would like to involve a member of their family or another person in management of their health care. Such disclosures of information are permitted by HIPAA when the patient (or his/her parent or guardian) designates an individual(s) as his/her Personal Representative. Therefore, if you would like to designate one or more individuals to serve as your Personal Representative, please complete the information below.

Name of Patient: _____ DOB: _____ Date: _____

I, the patient/parent/guardian hereby designate the individual(s) listed below to serve as my personal representative(s) or the personal representative of the name above. By designating this individual(s) as personal representative, I am giving permission to the physicians and the staff of Wilson Hand Surgery, PLLC to discuss any information pertaining to my healthcare (Including appointments, diagnoses, treatment plans, insurance information, and other clinical related topics)

This designation will remain in effect until such time as I revoke it in writing.

Name of Personal Representative	Relationship	Phone Number	Address

Dear patient, In the event that the physician is called out on an emergency and must cancel and reschedule your appointment, may we call your representatives here if we are not able to reach you through your primary phone contact? Signature here will allow us to call your contacts only if needed.

Signature of Patient/Parent/Guardian: _____

Relationship to Patient: _____

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AUTHORIZATION TO RELEASE CLINICAL INFORMATION

I, _____, authorize the named healthcare provider _____ to release clinical information and/or records to the specified provider.

PROVIDER: DR. BARBARA WILSON WILSON HAND SURGERY, PLLC 6560 FANNIN ST., SUITE 1810 HOUSTON, TX 77030 PHONE **(832) 530-4081** FAX **(877) 497-3616**	**PATIENT:** **LAST 4 OF SSN:** **DOB:** **PHONE #:**

RECORDS AUTHORIZED TO BE RELEASED:

- ☐ CLINICAL DOCUMENTS (H/P, DISCHARGE SUMMARY, OP- NOTE, CONSULTS)
- ☐ LAB REPORTS
- ☐ RADIOLOGICAL IMAGES AND REPORTS
- ☐ ALL OF THE ABOVE

THE AUTHORIZAED RECORDS WILL BE USED FOR:

- ☐ PHYSICIAN REQUESTED
- ☐ PERSONAL
- ☐ LEGAL REPRESENTATION
- ☐ OTHER: _____

This authorization will expire one year from the date listed below. I understand that I can revoke this authorization at any time by writing to Wilson Hand Surgery, PLLC. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I also understand that I am not required to sign this authorization and that my health care or payment for will not be affected by my refusal. Federal privacy regulations will no longer apply to the information disclosed. A copy of this authorization may be utilized with the same effectiveness as the original.

_____ _____ _____

Patient Name Patient Signature Date