

## Individual Patient's Authorization

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

**Psychotherapy notes:** \_\_\_\_ Check here if this authorization is for psychotherapy notes

If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected health information.

### I. Individual Patient (or Personal Representative) Confirming the Authorization

I give my authorization to use or disclose my protect health information as described in Section 2 below. I give this authorization voluntarily.

Your name: \_\_\_\_\_

Your street address: \_\_\_\_\_

Your city: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Your telephone number: \_\_\_\_\_

Your email address: \_\_\_\_\_

Your patient account number: \_\_\_\_\_

### II. The Use and/or Disclosure Authorized

Describe in detail the protected health information you are authorizing to be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed here):

Access procedure \_\_\_\_\_

Name of people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or disclose the protect health information described above.

Medical provider \_\_\_\_\_

Name the people and/or organizations (or the kinds of people and/or organizations) that your are authorizing to receive and use your protected health information.

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

Medical care \_\_\_\_\_

### 3. Ending This Authorization

Select one of the following two choices:

- This authorization will end on the following date: \_\_\_\_\_
- This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:
- \_\_\_\_\_

### 4. Changing Your Mind About This Authorization

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any action taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

### 5. Signing This Authorization is Not a Condition of Treatment

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

### 6. Possibility of Redisclosure

I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

### 7. Individual Patient's Signature

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

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

If this authorization form is signed by a personal representative of the individual patient:

Personal representative's name: \_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature

Relationship to patient: \_\_\_\_\_

**YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.**

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.

PATIENT NAME:

PATIENT ID:

FACILITY:

**PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY FORM**

By signing this Patient Authorization and Financial Responsibility Form ("Form"), I understand that I am personally responsible for the payment of vascular access procedures and other services that I receive at the above-listed outpatient facility ("Facility") that is managed/operated by Lifeline Vascular Access ("Lifeline"), at Facility's usual and customary fees (available for review upon request). My financial responsibility shall continue until insurance carriers reimburse Facility/Lifeline for such services, or Facility/Lifeline releases me from responsibility.

In return for Facility's treatment and services, I agree to the following:

- 1. Assignment of Benefits; Lien.** I hereby assign to Facility/Lifeline all of my rights, title and interest in any cause of action and/or payment due to me (or due to my dependants or my estate) under any employee benefit plan, insurance plan, union trust fund, or similar plan ("Plan"), under which I am a participant or beneficiary for services, drugs or supplies provided by Facility ("Services") to me or my dependants. I also hereby designate Lifeline as a beneficiary under any such Plan, and instruct that any payment be made solely and sent directly to Facility/Lifeline. If I receive any payment directly from any Plan for Services provided to me or my dependants by Facility, I agree to immediately endorse and forward such payment to Facility/Lifeline. I agree that Facility/Lifeline shall have an automatic lien against any such payment I receive from any Plan. **If I fail any of my obligations under this provision, I understand that Facility/Lifeline may pursue collections and legal action against me. In this case, I shall be responsible for the costs of collection (including reasonable attorneys' fees) that are incurred by Facility/Lifeline.**
- 2. Collection of Benefits/ Legal Action.** I agree to assist and cooperate with Lifeline to obtain payment from any Plan for Services, provided to me (or my dependants) by Facility. This includes, without limitation, my participation as a plaintiff in litigation, arbitration, appeal or other action or lawsuit, at Facility's expense, arising from dispute between Facility/Lifeline and any of the Plans relating any payment for my Services by Facility that is alleged by Lifeline.
- 3. Lifeline as Authorized Representative.** I hereby authorize Facility/Lifeline (including its attorneys and/or representatives) to act on my behalf or my dependant's or my estate's behalf, in pursuing benefit claims or appeals of adverse benefit determinations under any Plan. I hereby authorize Facility/Lifeline and its attorneys to pursue all available legal rights and remedies that they deem appropriate in order to collect from the Plans for such Services. I hereby agree to follow procedures established by any Plan to authorize Facility/Lifeline in this capacity.
- 4. Patient Deductible, Coinsurance and Co-payment.** For Medicare and certain other insurance companies where Facility accepts the charge determination as full payment, I am responsible only for my annual deductible, coinsurance and my co-payments, if any. If I am a Medicare beneficiary, such financial responsibility may apply to Lifeline performed clinical laboratory services.
- 5. Spend Down and Share of Cost (SOC).** I understand that if I participate in a State Medicaid program with a spend down, SOC or other cost sharing program that requires me to share in the cost of my healthcare, I agree to pay the amount of the spend down, SOC or other cost sharing at the time services are rendered, or when the spend down, SOC or other cost sharing amount is billed to me.
- 6. Successors, Heirs and Estate.** I desire that the obligations and representations contained in this document be binding on my heirs, legal representatives, successors and my estate. I agree not to assign my benefits under any Plan to any other person or firm for Services provided to me or my dependants by Facility.

This Form shall continue during treatment from Facility and thereafter, until Facility/ Lifeline is paid in full for Services provided to me or my dependants by Facility, or Facility/Lifeline's claim for payment is settled or withdrawn. I understand that if I do not fulfill the above terms and conditions, Facility/Lifeline may pursue payment from me directly, as appropriate, and/or ask me to immediately transfer to another vascular access center.

If any part of this form is deemed unenforceable, the remaining provisions shall remain in full force and effect. I understand I can hire an attorney at my expense to represent me in connection with this Form.

**This Form has been explained to me in person by the Lifeline teammate identified below:**

Print Patient/ Representative Name: \_\_\_\_\_

Print Teammate Name: \_\_\_\_\_

Representative Relationship to Patient: \_\_\_\_\_  
(If Applicable)

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

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

**Patient or Representative Signature:** \_\_\_\_\_

**Teammate Signature:** \_\_\_\_\_

## A Patient's Bill of Rights

It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. **The patient** has the right to considerate and respectful care.
2. **The patient** has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his/her behalf. He/she has the right to know, by name, the physician responsible for coordinating his/her care.
3. **The patient** has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to know the name of the person responsible for the procedures and/or treatment.
4. **The patient** has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.
5. **The patient** has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. Those not directly involved in his/her care must have permission of the patient to be present.
6. **The patient** has the right to expect that all communications and records pertaining to his/her care will be treated as confidential.
7. **The patient** has the right that within its capacity, this ambulatory surgery facility must provide evaluation, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. **The patient** has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him/her.



9. **The patient** has the right to be advised if this ambulatory surgery facility proposes to engage in or perform human experimentation affecting his/her care of treatment. The patient has the right to refuse to participate in such research projects.
10. **The patient** has the right to reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient's continuing health care requirements following discharge.
11. **The patient** has the right to examine and receive an explanation of his/her bill regardless of the source of payment.
12. **The patient** has the right to know what facility rules and regulations apply to his/her conduct as a patient.
13. **The patient** has a right to request information about the grievance process at the Center. If a patient has a grievance with the Center, he/she has the right to speak immediately with the Clinical Director or the substitute person assigned to answer to grievances. A formal written grievance may be completed for further review of the grievance.
14. **The patient** has a right to be free from chemical, physical and psychological abuse or neglect.

#### PATIENT RESPONSIBILITIES

**It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur.**

The patient is expected to follow up on his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels is necessary

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

Patient Signature  \_\_\_\_\_ Witness \_\_\_\_\_

## Questions and Complaints

If you have any questions about this notice or if you think that we have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a letter of complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

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We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

## Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on \_\_\_\_\_ and remains in effect until we replace it.

### 1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### 2. Our Legal Duty

#### Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current notice.

#### We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

#### Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### 3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to your or a third-party payer. The information on or accompanying the bill may include your medical information.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees,

conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes:

**Facility Directory:** Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name, your location in our facility, your condition described in general terms, your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

**Notification:** We will use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you the opportunities to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care.

**Disaster Relief:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Fundraising:** We may provide medical information to one of our affiliated fundraising foundation to contact you for fundraising purposes. We will limit our use and sharing of information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose to not receive future fundraising communications.

**Research in Limited Circumstances:** We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

**Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse event associated with product defects or problems, to enable product recalls, repairs or replacements, to track products or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk for contracting or spreading a disease or condition.

**Victims of Abuse, Neglect or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspections, licensure or disciplinary action or other authorized activities.

**Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises and crimes in emergencies.

**Appointment Reminders:** We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

**Alternative and Additional Medical Services:** We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you and to describe or recommend treatment alternatives.

#### 4. Your Individual Rights

##### You have a right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$ \_\_\_\_\_ for each page and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

**Privacy Practices Acknowledgement**

**Acknowledgement Form**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Original to chart – copy to patient**





Access Center Name: \_\_\_\_\_

**ACCESS CENTER PATIENT CONSENT TO  
RESUSCITATIVE MEASURES**

**NOT A REVOCATION OF ADVANCE DIRECTIVES  
OR MEDICAL POWERS OF ATTORNEY**

All patients have the right to participate in their own healthcare decisions and to make advance directives or execute Powers of Attorney that authorize others to make decisions on their behalf based on the patients' expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Access Center respects and upholds those rights.

However, unlike in an acute care hospital setting, this Access Center does not routinely perform high-risk procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risk, your expected recovery and care after your surgery.

Therefore, per our Rights of Patient policy regarding Advance Directives, regardless of the contents of any advance directive or instruction from a Health Care Surrogate or Attorney, if an adverse event occurs during your treatment at this Access Center we will initiate resuscitative or other stabilizing measures and transfer you to an Acute Care Hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measure already begun will be ordered in accordance with your wishes, Advance Directive or Healthcare Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure or to provide you with a list of facilities for your consideration that may agree to perform the procedure without suspending your Advance Directives.

Please check the appropriate box in answer to these questions. Have you executed an Advance Health Care Directive, a Living Will, a Power of Attorney that authorizes someone to make Health Care decisions for you?

- Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.
- No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.
- I would like to have information on Advance Directives.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.

By: \_\_\_\_\_  
(Patient's Signature)

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	DATE

If consent to the procedure is provided by anyone other than the Patient, this form must be signed by the person providing the consent or authorization.

**I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED.**

By: \_\_\_\_\_  
(Signature)  
\_\_\_\_\_  
(Print Name)

**RELATIONSHIP TO PATIENT**

- Court Appointed Guardian
- Health Care Surrogate
- Attorney in Fact
- Other \_\_\_\_\_



## **A Patient's Safety Education**

It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient safety education. It is in recognition of these factors that these rights and responsibilities are affirmed.

1. The patient has the right to report any concerns regarding safety to The Joint Commission.
2. The patient understands the importance and necessity for time-out procedure and marking the surgical site prior to the start of procedures.
3. The patient understands the importance and necessity for using correct identifiers for patient name and procedure to be performed.
4. The patient understands what process and procedures are done at this center to prevent infection and adverse events.

### **PATIENT RESPONSIBILITIES**

It is the patient's responsibility to fully participate in decisions involving his/her own safety and to accept the consequences of these decisions if complications occur.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

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



## Consent to Release Patient Records

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
to release records obtained in the course of my diagnosis and treatment to:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Parent (if patient is a minor) or  
Authorized Representative of Patient

\_\_\_\_\_  
Center Staff Member Witness

**NOTE: Patient's signature must be notarized if the form is not witnessed and signed by a staff member.**