Consent for Purpose of Treatment, Pay Healthcare Operations and Notice of Privacy Practices

I consent to the use or disclosure of my protected health information **Bay Cardiovascular Surgery, PA**, hereby referred to as Bay Vascular Surgery, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bay Vascular Surgery. I understand that diagnosis or treatment of me by **Lofton Misick, M.D. and/or other providers that are employed or contracted with Bay Vascular Surgery** may be conditioned upon my consent as evidence by my signature on this document. I understand that **Lofton Misick, M.D. and/or other providers that are employed or contracted with Bay Vascular Surgery** may provide care to me in facilities in which they may have a financial interest.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practices. Bay Vascular Surgery is not required to agree to the restrictions that I may request. However, if Bay Vascular Surgery agrees to a restriction that I request, the restriction is binding on Bay Vascular Surgery and

_____.

(Patient's name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that **Lofton Misick, M.D. or Bay Vascular Surgery** has taken action in reliance on the consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Bay Vascular Surgery's Notice of Privacy Practices prior to signing this document. The Bay Vascular Surgery Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bay Vascular Surgery. The Notice of Privacy Practices for Bay Vascular Surgery is also available at the front desk of each clinic. This Notice of Privacy Practices also describes my rights and the Bay Vascular Surgery duties with respect to my protected health information.

Bay Vascular Surgery reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Bay Vascular Surgery

Consent and Disclosure

Consent to Treat: I understand that as a patient I have the right to make all decisions regarding my care. I voluntarily request Dr. Lofton Misick, as my treating Physician, and associates of Bay Vascular Surgery, such as, a Physician Assistant/Nurse Practitioner, RN/LVN, technical assistants and other health care providers as deemed necessary, to treat my condition. I also understand that no warranty or guarantee has been made to me as to results or cure. I understand that my Physician and/or Physician Assistant may discover other or different conditions which require additional or different procedures than those planned. I authorize my Physician and/or Physician Assistant to perform such other procedures which are advisable in their professional judgment.

Specific Surgical/Diagnostic Procedures: _____

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Risk and Emergency: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the treatment.

Electronic Communication/Messaging: I authorize Bay Vascular Surgery to send communication via text message and/or by email.

Authorization to Release Information: I authorize Lofton Misick, MD to release any and all healthcare information as necessary to (a) obtain payment from my Payers for my healthcare, (b) to conduct utilization review, peer review, and quality assurance, and (c) to other healthcare providers that will assist with my care. I understand that this information will identify me and may relate to my history, diagnosis, treatment, or prognosis; it will also include, where applicable, psychiatric, alcohol abuse, drug abuse, specific laboratory results of HIV, or the diagnosis of AIDS. I understand that in the event of a healthcare worker being exposed to my blood or bodily fluids, my blood may be tested for the HIV antibody and other communicable diseases.

Financial Authorizations: I authorize all payers to directly pay Lofton Misick, MD for services provided. I assign to Lofton Misick, MD my right to receive payment from third-party payers. Third-Party payers include anyone from whom benefits are or may become payable to me for services provided.

Receipt of Information: I acknowledge that I have received the "Notice of Privacy Practices" and a copy of "Patients' Rights, Responsibilities and Healthcare Choices" from Lofton Misick, MD. I certify this has been fully presented and explained to me, that I have read it or have had it read to me, and that I understand its contents.

Financial Responsibilities: I understand and agree that I am responsible for payment of all charges that result from the care provided to me. I agree to pay these charges including payments not paid by my insurance company payers within 120 days. I understand that it is my responsibility to submit accurate insurance information on all dates of service and to comply with all requests of my insurance company within a timely manner to ensure payment is made within 120 days. I understand that if I am covered by Medicare/Medicaid, my obligation under this section may be limited by law. All payments, including co-payments, co-insurance, and deductibles, are due at the time services are rendered. I understand if balances on my account are not paid in a timely manner, they may be transferred to a third party for collections or further actions.

Medication History: I authorize Medication History Retrieval from the National database.

Property: I understand that Lofton Misick, MD does not assume responsibility for any personal property.

No Show/Late Appointment Policy: I understand that 24 hours' notice is required for appointment cancellations and that cancellations can and must be left on voicemail if after hours. After the second no-show, I understand and agree to a $15 nurse no-show fee, a $25 standard appointment no-show fee, or a $50 procedure no-show fee. All no-show fees are to be collected prior to the next scheduled appointment or before services are rendered. Workers' Compensation patients will be personally responsible for these amounts. After 3 No Shows on record, we reserve the right to conclude our relationship for noncompliance with the stated office policy. If you are more than 15 minutes late for your scheduled appointment, you may need to reschedule your appointment.

Request for forms: Due to the quantity and complexity of the forms requested, there will be a $25 charge, payable in advance, for the completion of each form requested.

Sunshine ACT Disclosure: In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufacturers in conjunction with product education. We do not receive direct financial compensation from any of our vendors. By initialing here, you acknowledge this disclosure.

PATIENT/ OTHER LEGALLY RESPONSIBLE PERSON (signature required): By signing, you certify that this form has been fully explained to you, that you have been given the opportunity to ask questions, and that you fully understand its contents.

Signature: _____ Date and Time: _____

Witness:

_____

Name: _____ Relationship _____