ADVANCED SURGICAL PHYSICIANS
ANDREW J. SHAPIRO, MD

1447 MEDICAL PARK BLVD, SUITE 407*WELLINGTON, FL 33414*PHONE: 561-333-1335*FAX: 561-333-4252

Updated February 2020

PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of the protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, its physicians, and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice, its physicians, and staff for the purposes of treatment, payment and healthcare operations (TPO). To that end, our practice, its physicians, and staff will -

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorization, as appropriate. Our practice, its physician, and staff will not use or disclose PHI for uses outside of practice's TPO, without authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice, its physicians, and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice, its physicians, and staff respect the patient's individual dignity at all times. Our practice, its physicians, and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will –
  - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - Not disclose PHI data unless the patient (or his/her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes information is inaccurate or incomplete. Our practice and its physicians and staff will -
  - Permit patient's access to their medical records when their written requests are approved by our practice. If we deny the request, then we must inform the patient that he/she may request a review of the denial.
  - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
  - Provide patients with an electronic copy of the medical record upon your written request and approval by the practice. If we deny the request, then we must inform the patient that he/she may request a review of the denial.

- All physicians and staff will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as the request is in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of the policy is grounds for disciplinary sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon release of a revised privacy policy and will be made available to patients upon request.

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PATIENT CONSENT OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give authorization to Advanced Surgical Physicians to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Andrew J. Shapiro, MD, PA's notice of Privacy Policy provides a more complete description of such uses and disclosures.)
I have the right to review the Notice of Privacy Policy prior to signing this consent. Advanced Surgical Physicians reserves the right to revise the Notice of Privacy Policy at anytime. A revised Notice Privacy Policy may be obtained by forwarding a written request to Advanced Surgical Physicians at 1447 Medical Park Blvd, Suite 407, Wellington, FL 33414.
With this consent, Advanced Surgical Physicians may call my home or other alternative location and leave a message on voicemail, with my spouse or myself in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
With this consent, Advanced Surgical Physicians may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. The practice is required to agree to my requested restrictions, if in writing.
Advanced Surgical Physicians will not disclose or sell PHI for marketing purposes or use your information to raise funds without your prior authorization.
Advanced Surgical Physicians will not disclose PHI to a health plan if you have paid for services in full out of pocket without your prior authorization.
If Advanced Surgical Physicians decides, it is authorized to use automated appointment reminders by phone or text message, but you have the right to opt out of these types of communications by providing that notification in writing.
If Advanced Surgical Physicians is notified or becomes aware of a breach in your PHI our staff will notify you in writing as soon as that breach has been discovered.
By signing the form, I am consenting to Advanced Surgical Physicians use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Surgical Physicians may decline to provide treatment to me.

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PATIENT FINANCIAL POLICY

Welcome to our practice! Our doctors are dedicated to providing the best possible surgical care and service to you. If you have any additional or specific questions, please contact our billing company. Our financial policy is:

- Unless you or your insurance company has made other arrangements, in advance, payment is due at the time of service. For your convenience, the office accepts cash, personal checks, credit cards, and debit cards.
- We are a participating provider for **Medicare**. You will be required to pay your Part B deductible unless your secondary insurance pays the deductible. You will be required to pay the 20% coinsurance unless your secondary insurance pays the coinsurance.
- If your physician is **NOT** a participating provider with your insurance company, we will file claims as a courtesy for you. Most insurance companies will send payment to the patient; therefore payment is due at time of service.
- If your physician **IS** a participating provider with your insurance company, we will file claims. You will be responsible for co-payments, coinsurance, and deductibles which are due at time of service.
- If your insurance company does not pay for services in a timely manner please understand that you will be held responsible for the entire amount of the submitted claim.

I hereby authorize the release of any information relating to claims for services that have been provided to me and/or dependents. I authorize Advanced Surgical Physicians to submit claims for services that have been provided to me and/or dependents, without having to obtain my signature on each and every claim for myself and/or dependent. I authorize payment to be sent directly to Advanced Surgical Physicians for services provided to me and/or dependents.

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Patient's Financial Responsibility Policy

Methods of Payment:

Acceptable methods of payment are cash, check (maximum $250 unless paid 14 days prior), credit cards, and debit cards.
Any check returned by your bank will incur a $25.00 fee.
If no insurance is on record, full payment is due at the time of service.

Payments and Balances:

- Copays, deductibles or coinsurances will be collected at check-in.
- Patients are responsible to know what their office visit responsibility is and to alert us of any change.
- Patients are responsible for surgical fees 72 hours prior to procedure. These fees may be paid over the telephone via credit card for your convenience.
- Past due balances are required to be paid in full prior to your next appointment.
- Refunds will be issued after all claims have been processed by insurance and posted in the account. Unfortunately, this can possible take up to 90 days after a claim is filed.
- Refunds for **cancelled procedures** will be reduced by $25.00 to cover processing fees incurred by the practice

Registration:

A fully completed, current patient registration will be on file in the patient chart during the time the patient is considered active.
Patient registration will be updated completely by the patient annually or upon any changes to maintain accurate information.
Signatures by the responsible parties are required on all forms.
Your insurance card will be scanned annually or upon any changes. It is the patient's responsibility to keep us informed of any changes regarding the registration and insurance.

Accounts Past Due:

Payment of statement is due upon receipt.
Non-payment may result in preparation of account for collections bureau, small claims court and discharge from the practice. If any account goes unpaid for a period of more than 60 days, it may be turned over to an outside collection agency. The person financially responsible for the account will be responsible for all collection costs, reasonable attorney fees and all court costs. Any account sent to collections may result in the patient, and all family members that the patient is responsible for as guarantor being dismissed from the practice.

Insurance Claims:

You, the patient, or adult responsible party are responsible to know and understand your insurance coverage. This includes verification that our physicians are providers within your insurance network. It is your responsibility to make sure we have current insurance information.

Claim Submission:

In the event the patient has insurance coverage but cannot provide documentation, charges will be entered as self-pay. Upon submittal of insurance card, we will submit a health insurance claim form. Secondary insurance is filed upon patient's submission of proof of secondary insurance.

Referrals:

Certain insurances require that you have a referral from your primary care physician. Please make sure that your PCP has been notified of this appointment and has provided us and you with a copy of that referral prior to your appointment. If a referral is not received by the time of your appointment we will need to reschedule your visit for another time. Our practice will make every effort to help you acquire this referral, but it is ultimately the responsibility of the patient.

Account Consultation/Financial Assistance:

OUR PHYSICIANS DO NOT DISCUSS FINANCIAL ISSUES. OUR BILLING STAFF IS TRAINED TO DISCUSS YOUR ACCOUNT AND CAN MAKE PAYMENT ARRANGEMENTS IF NECESSARY.

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Office Policies

FORMS AND RELEASE OF RECORDS:
The completion of administrative forms about your care and duplication of medical records is not a part of your routine medical services from us. We are happy to assist you in any way we can, but we reserve the right to charge appropriately for these extra services based upon time and effort involved. The minimum fee is $25.00 for the completion of administrative forms such as FMLA and disability claims. If you require a paper copy your medical records, in accordance with the State Law, our policy is to charge $1.00 per page for the first 25 pages, $0.25 per page for pages 26 and higher plus postage. Additional charges may apply for records that are STAT and that need to be certified. You may pick-up the records at our office or your records electronically downloaded to jump drive, that you provide, to save the postage fee. Records requests can be made through the Patient Portal at no charge and are completed typically within 24 hours.

- Requests must be made in writing by filling out our records release form or emailing a request through the patient portal.
- There is no cost to provide records to facilities or physicians that we refer you to see.
- Please allow up to 10 business days for records to be available for pick up or delivery.
- Please allow up to 3 business days for FMLA and disability claims to completed.

Patient Portal: We invite you to use our patient portal. It is available for access via our website **advancedsurgicalphysians.com or directly at myhealthrecord.com.** Once you provide an email address to our office, you will be sent an email with instructions for activation. Once activated, we can provide you with access to appointment requests, clinician question requests, and availability to your lab work, pathology and operative reports after any required follow up appointments.

Results: **It is the policy of our practice not to release results via mail, email, portal or telephone until the doctor reviews the results with you in person.** When you are scheduled for any diagnostic testing, blood work, surgery/biopsy, or any in-office procedure, you must have a follow up appointment for results and continuation of care. It is your responsibility to make and keep all scheduled appointments for your follow-up care. If you cannot make an appointment it is your responsibility to reschedule that appointment.

Minors/Dependents:
Children under the age of 18 will require the signature of a responsible adult party on the registration form. We cannot treat an unaccompanied minor.

Cancellation Policy: As a courtesy to the practice and other patients we request 48 hour notice of cancellation of office appointments. Except for illness or delays due to medical clearance, we require one week notice of cancellation or rescheduling of any hospital or office surgical procedure. A fee may apply for cancellations not completed within the above time frame. Patients that need to reschedule a procedure more than one time not related to medical clearance issue will be required to make a $250 deposit that will be applied to your balance. All refunds will be made according to our office policy if the deposit exceeds the fees.

Use of Electronic Devices- Due to the sensitive nature of our practice we request that you limit the use of electronic devices while in the office. Please use appropriate headsets for streaming music, games and videos. Please step out of the office if you would like to take a phone call. Once you enter the exam room with the physician we request that your device be turned off. Unless a special request has been made and approved, there is no audio or video recordings of appointments is permitted. Guest WIFI is provided for you.

Refills of Medication: Narcotic pain medication cannot be called in over the telephone. You may be required to see the doctor before any medication can be refilled.

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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health Information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities: We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Access to electronic records: The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for electronic copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request: If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form.

ANDREW J. SHAPIRO, M.D., P.A.
1447 MEDICAL PARK BLVD.#407
WELLINGTON, FL 33414
561-333-1335

Update 9/13

Patient Printed Name:______________________________ **Date of Birth:**______________

Guarantee of Payment

PAYMENT GUARANTEE

I have been provided and had the opportunity to review the Patient Financial Responsibility and Patient Financial Policies.

Patient Signature:______________________________ Date:__________

Responsible Party Signature:__________________ Relationship:__________ Date:____________

Consent to Medical and Surgical Treatment

Consent

The undersigned hereby consents to all medical care and services, surgical treatment, tests, and procedures, including, but not limited to radiological studies, laboratory and diagnostic procedures, and anesthesia, which a physician, their employees, nurses, or designees may deem advisable to the undersigned patient during this treatment.

Patient Signature:______________________________ Date:__________

Responsible Party Signature:__________________ Relationship:__________ Date:____________

If patient is under age 18, I herby give my permission for __________________ to be treated by Advanced Surgical Physicians, Andrew J. Shapiro, MD

Assignment of Insurance Benefits

Assignment of Benefits

I hereby authorize payment directly to Advanced Surgical Physicians (ASP) and assign to them any and all rights and benefits that I or the patient may have under any policy of insurance including medical, automobile, personal injury protection, worker's compensation, or any other coverage further direct any such insurance company make payment of benefits directly to ASP. I understand that I am financially responsible to ASP. I understand that I am financially responsible to ASP for charges not covered by this assignment.

Lifetime Signature Authorization: I hereby authorize ASP to furnish to my insurance company or their representative, or Social Security Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of ASP any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.

Patient Signature:______________________________ Date:__________

Responsible Party Signature:__________________ Relationship:__________ Date:____________

Notice of Privacy Policy

Privacy Policy

I have been provided and had the opportunity to review the Privacy Policy.

Patient Signature:______________________________ Date:__________

Responsible Party Signature:__________________ Relationship:__________ Date:____________

Patient Consent of Use and Disclosure of Protected Health Information

Consent and Use of PHI

I hereby give authorization to Advanced Surgical Physicians (ASP) to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (ASP's notice of Privacy Policy provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Policy prior to signing this consent. Advanced Surgical Physicians reserves the right to revise the Notice of Privacy Policy at anytime. A revised Notice Privacy Policy may be obtained by forwarding a written request to Advanced Surgical Physicians at 1447 Medical Park Blvd, Suite 407, Wellington, FL 33414.

With this consent, ASP, may call my home or other alternative location and leave a message on voicemail, with my spouse or myself in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, ASP may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. The practice is required to agree to my requested restrictions, if in writing.

By signing the form, I am consenting to ASP to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, ASP may decline to provide treatment to me.

Patient Signature:______________________________ Date:__________

Responsible Party Signature:__________________ Relationship:__________ Date:____________

Notice Physician Financial Responsibility Coverage

Malpractice

I have been provided and had the opportunity to review the Notice Physician Financial Responsibility Coverage.

Patient Signature:______________________________ Date:__________

Responsible Party Signature:__________________ Relationship:__________ Date:____________

Notice of Office Policies

Office Policies

I have been provided and had the opportunity to review the office policies regarding forms and release of records, availability of the patient portal, reporting results, cancellation policy, use of electronic devices, and refills of medication.

Patient Signature:______________________________ Date:__________

Responsible Party Signature:__________________ Relationship:__________ Date:____________

Notice of Privacy Acknowledgement

Advanced Surgical Physicians, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

______________________________ ______________

Patient Name or Legal Guardian (print) Date

____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: ____________ Attempt: ______________________________

Staff Name: ______________________

ADVANCED SURGICAL PHYSICIANS
Andrew J. Shapiro, MD, PA
1447 Medical Park Blvd. Suite 407
Wellington, FL 33414
Phone: 561-333-1335 Fax: 561-333-4252

Under Florida law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

Your doctor has decided not to carry medical malpractice insurance.

This is permitted under Florida Law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

*Patient Signature ____________________ Date_______

Print Name____

My signature acknowledges that I have read and understand the above notice.

Advanced Surgical Physicians, LLC
1447 Medical Park Blvd, Suite 407 – Wellington, FL 33414
Office: (561) 333-1335 – *Fax:* (561) 333-4252

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

____
(Practice Name)

Patient Name: ______________________ ID Number: ______________________

Date of Birth: ______________________

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	Persons/organizations receiving the information:
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

______________________________ ______________________

Signature of Patient or Legal Representative Date

______________________________ ______________________

If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

E-mail Consent Form

Patient Name ____ Date _______________

Patient E-mail address ____________________ Patient phone number ____________________

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-

mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS:**

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. **TERMINATION OF THE E-MAIL RELATIONSHIP**

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

E-mail Consent Form

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) ______________________________

Patient Signature ______________________________ Date ____________________

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) ______________________________

Patient Signature ______________________________ Date ____________________

Medical History

Name_______________________________________ Date of Birth_________________

Height:_______________ Weight_______________

What is the reason for your visit today? ____

Allergies to Medications:____

What Health problems do you have? Please circle yes/no for each

Heart attack	y/n	Cancer	y/n	Anemia	y/n
High blood pressure	y/n	Asthma	y/n	HIV+	y/n
Irregular heartbeat	y/n	Depression/anxiety	y/n	High cholesterol	y/n
Diabetes	y/n	Heart disease	y/n	Heart failure	y/n
Stroke	y/n	COPD	y/n	Chronic pain	y/n
Blood Clot	y/n	Thyroid disease	y/n	Kidney disease	y/n
Other:					

Medications List	Reason

What types of surgery have you had in the past?

Marital Status? Married Single Divorced long term relationship Widowed

Smoking History? Never _______________ Current_____________ Former_____________

Alcohol? Never _______________ Current_________ Social/Moderate/Heavy

Recreation Drug Use? Never _______________ Current_________ Social/Moderate/Heavy

Do you have a family history of the following? Circle Yes/no for each

Heart Disease	y/n	Cancer/Type____________	y/n	Breast Cancer? Who?____________	y/n
Diabetes	y/n	Asthma	y/n	COPD	y/n

Required by government mandate- You have the right to refuse to answer

Language: ___________

Race: _______________

Pharmacy with Phone number____

Ethnicity: _____________

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Version 3.24

Telehealth informed consent form

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "Telehealth Informed Consent" informs the patient ("patient," "you," or "your") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services provided:

Telehealth services offered by Advanced Surgical Physicians, LLC (**"Practice"**), and the Practice's engaged providers (our **"Providers"** or your **"Provider"**) may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the **"Services"**). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

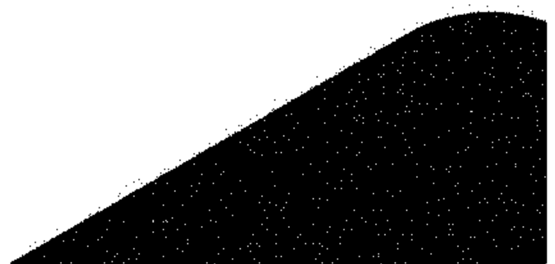
Electronic transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling
- Completion of medical intake forms
- Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communications
- Two-way interactive audio in combination with store-and-forward communications between you and your Provider
- Two-way interactive audio-video interaction between you and your Provider
- Review and treatment recommendations by your Provider based upon output data from medical devices and sound and video files
- Delivery of a consultation report; and/or other electronic transmissions for the purpose of rendering clinical care to you

Expected benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available by appointment only.
- Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by calling the office at 561-333-1335. If the office is closed you will be directed to our answering service and your call will be returned as quickly as possible.



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- More efficient care evaluation and management. Please continue to use the patient portal for another form of communication which will be checked between 4-6 times per day. You will get a response via the portal or a phone call.

Service limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT ADVANCED SURGICAL PHYSICIANS, LLC OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.**
- If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 561-333-1335, the portal email system, or as a last case ajsmdpa@yahoo.com.
- The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.

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Patient acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.
2. I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials.
3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.
5. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, at the direction of our Providers.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.
8. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.
9. I understand I have the right to object to the videotaping of the telehealth consultation.
10. I understand there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.
11. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.
12. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state.
13. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.

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14. I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send copy of my medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery.
15. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
16. I understand that I may not be covered under my current health insurance plan for telehealth services.

Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

☐ **ACCEPT.** By checking the Box for this **"TELEHEALTH INFORMED CONSENT"** I hereby state that I have read, understood, and agree to the terms of this document.

Patient's name	Parent/Legal guardian's name
Patient's signature	Parent/Legal guardian's name
Date	Date