ADVANCED SURGICAL PHYSICIANS

AUTHORIZATION TO RELEASE BILLING INFORMATION:

I hereby authorize the treating provider to release any information required in the course of my examination or treatment to my insurance company, providers, individuals and entities authorized by me or their contracted entities. If the patient is a minor, the parent or legal guardian must sign.

Please note that the use of all daily authorized and released records are not under Advanced Surgical Physicians, LLC's control.

AUTHORIZATION FOR PATIENT PICTURE:

I hereby authorize Advanced Surgical Physicians, LLC to take a picture for my electronic medical records if I do not produce a current Photo ID.

ASSIGNMENT OF BENEFITS

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payers, for service rendered by Advanced Surgical Physicians, LLC, and the medical professionals caring for me during my treatment in this office to be paid directly to Advanced Surgical Physicians, LLC, or other associated providers as appropriate. I understand that I am responsible for all charges not paid by insurance.
This assignment will remain in effect until revoked in writing by me.

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient Printed Name Date of Birth

ADVANCED SURGICAL PHYSICIANS

Patient's Financial Responsibility

Methods of Payment

All payments are made **electronically** through our online payment system. The use of a credit card with be subject to a 3% convenience fee. Other forms of payment accepted without a fee are Debit Card, ACH, cash and check. All returned checks will incur a $50 fee.

Payments Due and Balances

- Copays, deductibles and Coinsurances will be calculated and collected at check in at every appointment
- You are responsible to know and understand your insurance benefits for a specialist prior to your appointment.
- Surgical Fees are due 1 week prior to your procedure. A link via text or email will be sent for your convenience. Procedures are subject to cancellation for failure to make estimated payment on time.
- Past due balances are required to be paid before your next appointment or procedure.
- Refunds not including convenience fees will be issued after **all** outstanding claims have been processed by the insurance and posted to your account. This can take up to 90 days after a service is provided.
- Refunds for cancelled procedures not related to medical clearance will be reduced by $50. We ask for a two week cancellation or reschedule notice in order to fill open slots from the wait list.
- Balances are due at statement receipt. Past due balances are subject to collections and could result in dismissal from the practice.

Registration information for claims

- It is your responsibility to provide accurate and up to date insurance information for your visit. Failure to do say will result in your account becoming self pay.
- It is your responsibility to provide accurate name and date of birth at the time of your visit for insurance verification.

Insurance claims

It is your responsibility to provide current insurance information, know and understand your insurance coverage to include benefits and need for referrals, and verify that our providers are within your insurance network

Referrals for HMO plans

Some insurances require that you have a referral from your primary care doctor and not the doctor that recommended our providers. It is your responsibility to let your primary care doctor know that you have an appointment and you secure your referral. We will request one on your behalf with proper codes, but ultimately it is the responsibility of the patient to obtain the referral, and you can not be seen using your insurance benefits without a valid referral on file.

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient Printed Name Date of Birth

ADVANCED SURGICAL PHYSICIANS

Office Policies

Forms

Completion of administrative forms such as FMLA, disability, travel cancellations, detailed letters about your care, or paper medical records is not part of routine medical services. While we're happy to help, these requests require time and may incur fees. The minimum fee for forms and detailed letters is $35; extensive packets or revisions may incur additional fees. Please allow 7-10 business days for processing.

Release of Records

- Records can be made available upon request to the patient portal or via email once proper consents have been signed
- Printed medical records will have a fee of $1.00 per page for the first 25 pages and $0.25 for every page after. Additional charges will apply for STAT or certified requests
- Portal records will be made available within 48 hours, allow up to 10 days for printing of paper records
- Records will be released automatically to providers we refer you to, or that referred you to us. All other releases will require a signed release form by the patient.

Patient Portal

- Please find the link on our website www.advancedsurgicalphysicians.com. Let us know if you need a link to reset your password.
- Email address is required

Results

There are NO results that will be released over the portal or via telephone interaction with the physician or staff. All results are discussed in person with the provider. It is the patient's responsibility to ensure you have a follow up appointment scheduled. Although we will make every effort to ensure you have the proper follow up, Do NOT rely on our staff to call you.

Minors and Dependents

Children under the age of 18 will require the presence and signature of a parent or guardian

Cancellation Policy

We have a robust reminder system for your appointment. It is your responsibility to ensure we have updated phone numbers in our system. Please give a minimum 48 hour notice for appointment cancellations and 1 week for surgery cancellations. Be sure to complete medical clearances in enough time to allow for this.
If surgery needs to be rescheduled more than 1 time, a $250 deposit that will be applied to your balance or refunded to you will be collected to hold the slot.

Electronic Device Use

- Headsets must be used to listen to music or videos on personal devices.
- All phone calls must be taken in the hallway.
- Please silence phone ringers when you enter the office.
- Unless there is a request with approval, there is no audio or video recordings in the office setting allowed
- Guest Wifi is provided for you.

Medication and Refills

- All medications are filled electronically. It is your responsibility to provide the information for your pharmacy and update as needed.
- You may be required to have an office visit to refill narcotic pain medications

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient Printed Name Date of Birth

ADVANCED SURGICAL PHYSICIANS

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 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 judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida Law

Patient/Guardian Signature

Date

Patient Printed Name

Date of Birth

ADVANCED SURGICAL PHYSICIANS

This medical practice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This medical practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This medical practice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
  - Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, contact the office administrator.
- If you believe that this medical practice has failed to provide these services or discriminated in another way on
- the basis of race, color, national origin, age, disability, or seek, you can file a grievance with the office administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance,

the office administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at

https://ocrportallhs.gov/ocriportal/lobby.,_.isf,. or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HMI Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at httR:l /www.hhs.gov/ocr/officeifile/index.html.

Patient/Guardian Signature

Date

Patient Printed Name

Date of Birth

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 medical 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. All complaints must be made in writing.

You will not be penalized for filing a complaint.

ADVANCED SURGICAL PHYSICIANS

1447 Medical Park Blvd Ste 407
Wellington, FL 33414

Office: 561.333.1335
Fax: 561.333.4252

Attn: Compliance Contact

Please sign the accompanying "Acknowledgement" form

Notice of Privacy Practice 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/Guardian Signature

Date

Patient Printed Name

Date of Birth

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: _____

E-mail Consent & Acknowledgment Form

Advanced Surgical Physicians, 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:
  - E-mails can be circulated, forward, and stored in numerous paper and electronic files.
  - E-mails can be immediately broadcast worldwide and be received by unintended recipients.
  - E-mail senders can easily type in the wrong email address.
  - E-mail is easier to falsify handwritten or signed documents.
  - Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
  - Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
  - E-mail can be intercepted, altered, forward, or used without authorization or detection.
  - E-mail can be used to introduce viruses into the computer system.
  - 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 patient's 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 patient's 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.
- d. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
- e. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- f. It is the patient's responsibility to follow-up and/or schedule an appointment.

E-mail Consent & Acknowledgment Form

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.

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 email 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.

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/Guardian Signature Date

_____ _____

Patient Printed Name Date of Birth

Advanced Surgical Physicians, LLC
1447 Medical Park Blvd, Suite 407 Wellington FL 33414
561.333.1335 561.333.4252

Authorization To Disclose Health Information

Date: _____

Patient Name _____ 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 if the organization authorized to receive the information in not a health plan or health car provider, the released information may no longer by protected by federal privacy regulations.

Persons/Organizations providing the information	Persons/Organizations receiving the information
Description and Dates	Purpose of requested use or disclosure

Patient or Representative read and initial the following statements:

1. I understand that this authorization will expire on _____ . If no date is specified this will expire in six months. _____

2. I understand that I can revoke this authorization at any time by notifying the provider in writing. I understand that this does not pertain to information that has already been released and does not apply to insurance claims _____

3. If I have questions about disclosure of my health information, I can contact the office. _____

_____
Signature of Patient or Representative Date

_____
Relationship to Patient