CENTER OF SURGICAL SPECIALISTS, P.C.
Notice of Privacy Practices for Protected Health Information
Effective Date: April 14, 2003

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!

USES AND DISCLOSURE OF HEALTH INFORMATION

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Some examples of uses or disclosure of your health information for these purposes are:

- Sharing notes and reports or test/pathology results with other health care providers for ongoing treatment of your condition or referral to another physician.
- Obtaining information about you which is recorded in your health record.
- Providing your diagnosis and/or other information about your health to your insurance company to obtain payment for the health care services we provide.
- To obtain services from our insurers or other business associates such as quality assessment, quality improvement, training programs, credentialing, medical review, legal services, accounting services and insurance.

OTHER USES AND DISCLOSURES

The office may create and distribute de-identified health information by removing all references to individually identifiable information. The office may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Providing you with information related to your health;
- Contacting you regarding appointments, information about treatment, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.);
- Informing a family member, other relative, or close personal friend when:

  - Information is relevant to the individual's involvement with your care;
  - To notify of your location, general condition or death;
  - To assist in your health care (e.g., pick up prescriptions or other documents, note follow up care instruction, etc.).
- Compliance with all laws, (including reports of suspected abuse, neglect or violence);
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
- Providing certain specified information to law enforcement or correctional institutions;
- Responding to court or administrative tribunal orders, subpoenas, discovery request or other lawful process;
- Public health activities when requested by a public health authority or the FDA;
- Responding to health oversight agencies;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities; or
- Providing information regarding your location, general condition or death to public or private disaster relief agencies.

Any other uses or disclosures will be made only with your written authorization which may be revoked at any time.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request restrictions on certain uses and disclosures of your health information by delivering the request to our office. However, we are not required to grant the request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health and billing record with some limited exceptions – you may exercise this right by delivering a written request to our office. Please be advised there is a charge to inspect and copy your records. This request will be granted within thirty (30) days for on-site records and sixty (60) days for all records located outside our office. An extension of no more than thirty (30) days is allowed if we provide you with a written notice of the reason for the delay as well as the date we will complete your request;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information. You must submit this request in writing to our office and provide the reason(s) supporting the requested amendment. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the office;
- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.

Demographic information (e.g.: name, address, phone number, etc.) may be changed as opposed to being formally amended.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a written statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Crystal Keefer, Privacy Officer, 9351 Grant St, Suite 400, Thornton, CO 80229, 303-452-0059, in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

OUR RESPONSIBILITIES

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Crystal Keefer, Privacy Officer, at 303-452-0059.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Crystal Keefer, Privacy Officer, Center of Surgical Specialists, 9351 Grant St, Suite 400, Thornton, CO 80229. You may also file a complaint to the Secretary of Health and Human Services, Office of Civil Rights, 200 Independence Ave, SW, Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

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Name of Patient (please print) **Date of Birth**

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Center of Surgical Specialists, P.C.'s Notice of Privacy Practices.

Signature of patient or patient representative Date

****

For office use only

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
_____
_____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):
_____
_____

Signature of Employee Completing Form Date

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Financial Policies and Information

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's training and education, supplies, and support costs associated with providing and coordinating your care.

Insurance: It is the patient's responsibility to provide us with current insurance information. For verification, please have your current insurance card and photo ID available at every appointment. As a courtesy, we will file claims to your insurance company. Your insurance coverage is a contract between you and your insurance plan. Knowing your insurance benefits – including eligibility and covered benefits is your responsibility; please contact customer service at your insurance company for questions you may have regarding your coverage.

Patient Balance: All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with our billing department. We can extend interest free, short-term financing. Depending upon your balance and the services rendered, we can offer six (6) and twelve (12) month plans. Please contact our billing department to discuss this further. Payment may be made by cash, check, VISA, MasterCard or Discover.

We also provide the option of keeping your credit card on file to use for account balance after insurance processing (upon receiving explanation of benefit) which can include but are not limited to co-payment, coinsurance or deductible. You will be contacted by the billing department of any credit card transactions.

Card Type _____ Card # _____ Exp. Date _____

Card Holder's Name (print) _____ Signature _____

Failure to comply with these payment policies may result in your account being reviewed to be referred to an outside collection agency.

Patients without Insurance: For those patients that do not have insurance coverage, a prompt pay discount can be offered. Please contact our billing department for additional details.

Cancellations/Rescheduling Appointments: Once your appointment time has been reserved for you, we trust that you will be present. To assist patients with access to our physicians, our office does require 24 hour notice to cancel/reschedule appointments. If we do not receive such notice, you will be charged $50 for any missed appointments. Cancellation fees are not covered by insurance and these charges will be your responsibility and billed directly to you.

Medical Forms (FMLA, Work Comp, etc): The completion of disability forms, attending physician statements and other supplemental insurance forms require additional physician and staff time. The first form will be no charge to you. A recurring fee of $25.00 will be charged for additional forms.

Collection Agencies: If it becomes necessary to place your account with a third party collection agency due to your non- payment, the account of the person responsible will be turned over to collections.

Non-Sufficient Funds: A $35.00 fee will be charged for each check returned by the financial institution. You may be placed on a cash or credit card payment method following any returned checks and you must pay any balance due immediately.

Your signature on this page constitutes an agreement to this policy.

Please keep in mind our doctors are general and trauma surgeons. There will be times when our doctors may be called out of the office unexpectedly. We appreciate your understanding and patience if this occurs during your appointment time.

I have read and understand the financial policy of this practice, and I agree to be bound by its terms. I authorize payment directly to Center of Surgical Specialists, PC, for medical benefits.

Signature of Person Responsible for Account/Patient _____ Date _____

Printed Name _____

Witness _____

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Minor's Information Sheet

Child's Name:_____ Date Of Birth_____/_____/_____

Address:_____Apt#:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Social Security Number:_____

Allergies to Medication:_____ Sex: Male/ Female

Mother's Information

Name:_____

Social Security#:_____

Date of Birth:_____/_____/_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Employer:_____

Work Phone:_____

Father's Information

Name:_____

Social Security#:_____

Date of Birth:_____/_____/_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Employer:_____

Work Phone:_____

Referring Physician

Name:_____

Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Care Physician

Name:_____

Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

*****In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be filled our completely**

Primary Insurance

Insurance Company:_____

Group Name/Number:_____

Policy Number:_____

Policy Holder Name:_____

Policy Holder Date of Birth: _____/_____/_____

Copayment Amount:_____

Secondary Insurance

Insurance Company:_____

Group Name/Number:_____

Policy Number:_____

Policy Holder Name:_____

Policy Holder Date of Birth: _____/_____/_____

Copayment Amount:_____

Emergency Contact Person

Name:_____ Phone:_____

Relationship:_____ Work Phone:_____

I HEREBY ASSIGN TO THE DOCTORS WHOSE NAME APPEARS ABOVE, ALL BENEFITS FOR MEDICAL AND/OR SURGICAL EXPENSE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO SAID DOCTORS FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

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Patient History Form **DATE:** _____

Patient Name: _____ Age: _____ Date Of Birth: _____

The following information is very important to your health. Please take time to fully and completely fill out these forms. Important decisions are based on this information.

Height: _____ Weight: _____

ALLERGIES: Are you allergic to any medications (including over-the-counter drugs or iodine, tape or latex)?
Circle one: Yes No If yes, please complete the following:

Drug Allergy:	Reaction:	Other Allergy:	Reaction:
_____		_____	
_____		_____	
_____		_____	
_____		_____	

MEDICAL PROBLEMS: Please list **all** medical problems you have.

_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS: Please list **all** medications (specify dosage and frequency) you are currently taking, including aspirin, over-the-counter medications, vitamins and herbal supplements.

_____	_____
_____	_____
_____	_____
_____	_____

Please list your PAST medications.

_____	_____
_____	_____
_____	_____

OPERATIONS: Please list **all** operations you have had.

Operation:	Date:	Operation:	Date:
_____		_____	
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY:
Do you use any type of tobacco product? Yes No If yes, how much per day _____
Have you EVER used any type of tobacco product? Yes No Date Quit _____
Do you drink alcohol? Yes No If yes, how often? _____
Do you use illicit drugs? Yes No If yes, please list: _____
For women: Last menstrual period: _____ Number of Pregnancies: _____ Number of Live Births: _____

Physician Signature: _____ **Date:** _____

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Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: Have you been diagnosed with and/or are you currently having any of the following symptoms? Please check all that apply.

Neurologic/HEENT:
Have you had any neurological problems? Yes___ No___
___ Numbness/tingling
___ Loss of strength
___ Stroke (CVA/TIA)
___ Headaches-type _____
___ Seizures/epilepsy
___ Multiple Sclerosis
___ Ear problems
___ Eye problems
___ Nose/sinus problems
___ Throat problems

Musculoskeletal/Skin:
Have you had any muscle/bone problems? Yes___ No___
___ Back or neck problems/Joint pain
___ Loss of sensation
___ Rash/skin breakdown
___ Arthritis-type _____
___ Fractures-type _____
___ Osteoporosis

Endocrine:
Have you had any endocrine problems? Yes___ No___
___ Tired/Sluggish
___ Excessive thirst
___ Diabetes
___ Thyroid problems

Respiratory:
Have you had any breathing problems? Yes___ No___
___ Wheezing
___ Shortness of breath
___ Productive or bloody cough
___ Asthma
___ Emphysema/COPD
___ Bronchitis
___ Pneumonia
___ Sleep apnea
___ Pulmonary embolism

Cardiac:
Have you had any heart problems? Yes___ No___
___ Chest pain (Angina)
___ Palpitations/heart racing
___ Congestive heart failure
___ Heart attack
___ High blood pressure
___ Pacemaker
___ Heart valve
___ Rheumatic fever

Blood/Immune System:
Have you had any problems? Yes___ No___
___ Swollen glands
___ Anemia
___ Cirrhosis
___ DVT/phlebitis/blood clots
___ Jaundice
___ Lupus
___ Bleeding disorders
___ Scleroderma

Digestive (Stomach/Bowel):
Have you had any digestive problems Yes___ No___
___ Abdominal pain
___ Nausea/vomiting
___ Constipation
___ Diarrhea
___ Colitis
___ Diverticulitis
___ Hiatal hernia/reflux disease
___ Irritable bowel syndrome
___ Ulcers
___ Pancreatitis
___ Rectal Bleeding/rectal pain
___ Change in bowel habits
___ Hemorrhoids

Genitourinary/GYN:
Have you had any problems? Yes___ No___
___ Kidney problems/stones
___ Bladder infections
___ Kidney failure
___ Hernia
Men:
___ Prostate problems
___ Loss of sexual function
Women:
___ Uterine problems
___ Ovarian problems
___ Infertility
___ Bleeding between periods
___ Ever taken birth control pills? When: _____
___ Complications from childbirth

Constitutional:
Have you had any problems? Yes___ No___
___ Fever
___ Chills
___ Weight Loss
___ Night sweats

Communicable Diseases:
Have you had any problems? Yes___ No___
___ AIDS/HIV
___ Hepatitis A/B/C
___ Sexually transmitted disease
___ Tuberculosis

Psychological (Emotional):
Have you had any problems? Yes___ No___
___ Nervousness
___ Anxiety
___ Depression
___ Other _____

Physician Signature: _____

Date: _____

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Patient Name: _____ Date of Birth: _____

Cancer:

Have you ever been diagnosed with cancer? Yes___ No___

Type of Cancer:	Treatment:

Other:
Have you had any other medical problems not listed here?
Yes___ No___ Please list below:

_____

_____

_____

FAMILY HISTORY:

Please check which, if any, of your blood relatives had any of the following conditions:

Condition	**Parent**	**Siblings/ Children**	**Other Relatives** (Grandparents, Aunts, Uncles, Cousins, etc.)	**No Family History**	**Don't Know**
Diabetes					
Heart Disease					
Hypertension					
Gallstones					
Obesity					
Sleep Apnea					
Asthma					
Blood clots					
Cancer					
Stroke					
Kidney Disease					
Bleeding Problems					
Gout					
Allergies					
Dermatitis/Eczema					
High Cholesterol					
Osteoporosis					
Autoimmune Disease					
Psychiatric Illness					

Physician Signature: _____ **Date:** _____

******No changes to history******

Physician Signature: _____ **Date:** _____

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PATIENT HIPAA QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name _____ Phone_____

Name _____ Phone_____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:
( )_____

*** I am fully aware that a cell phone is not a secure and private line.**

**** I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.**

VI. Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail?

YES_____ NO _____

PATIENT NAME_____

PATIENT/GUARDIAN SIGNATURE_____

DATE _____