Advanced Surgical Care

Protected Health Information

10/26/2016

I understand that as part of my healthcare, the Clinic originates, records, and maintains protected health information about me describing my health history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this protected health information may be used and disclosed by the Clinic for treatment, payment, and healthcare operations. For example, my protected health information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and procedures to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine heath care operations, such as assessing quality and reviewing the competence of healthcare professionals

I acknowledge that I have been provided with the Clinic's Notice of Privacy Practices that provides me a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Clinic reserves the right to change its Notice of Privacy Practices and a revised copy will be given to me at my next visit at the Clinic.

_____ _____

Signature *Date*

I understand that I have the right to request restrictions as to how my protected health information may be disclosed to carry out treatment, payment or heath care operations. I further understand that if it is my request to restrict the release of my protected health information to my insurance company from a particular visit, I will be required to pay for that visit in full at the time of service. The Clinic is not required to agree to the restrictions as requested, but if it does, it is bound by such restrictions. I understand that I may revoke this consent in writing, except to the extent that the Clinic has already taken action in reliance thereon. By signing this form, I consent to the Clinic's use and disclosure of my protected health information for treatment, payment, and healthcare operations.

_____ _____

Patient Name (Printed) *Date*

_____ _____

Signature of Patient or Legal Representative *Date*

_____ _____

Witness Signature *Date*

Consent to Medical Treatment

I, (for) the undersigned patient, do hereby voluntarily consent to such care involving routine diagnostic procedures and medical treatment by the Clinic. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this visit.

_____ _____

Patient Name (Printed) *Date*

_____ _____

Signature of Patient or Legal Representative *Date*

_____ _____

Witness Signature *Date*