NORTH ATLANTA EAR, NOSE AND THROAT SURGICAL CENTER

NOTICE OF PRIVACY PRACTICES AND RESPONSIBILITIES

HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

FOR PAYMENT. We may use and disclose medical information about you so that the treatment and services you receive at the facility may be billed to and payment may be collected from you, an insurance company or a third party.

FOR TREATMENT. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are involved in taking care of you at the facility or the hospital.

FOR HEALTH CARE OPERATIONS. We may use and disclose medical information about you for health care operations such as quality improvement efforts. These uses, and disclosures are necessary to run the facility and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other facility personnel for review and education purposes.

WHO WILL FOLLOW THIS NOTICE. Any health care professional authorized to enter information into your medical chart including all facility doctors, nurses and personnel will abide by this notice.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the facility. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel or by your doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for public health-related benefits and services; to individuals involved in your care or payment for your care; research; and to avert a serious threat to health or safety. Other uses and disclosures of your personal information could include disclosure to, or for: medical examiners; law enforcement; lawsuits and disputes; military and veterans; national security; public health risks; and worker's compensation.

PATIENT RESPONSIBILITIES

The care a patient receives depends partially on the patient himself. Therefore, in addition to a patient's rights, the patient has certain responsibilities as well. These responsibilities are, in the spirit of mutual trust and respect, to:

1. Provide accurate and complete information about present complaints, past illnesses, hospitalizations, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities, and other matters related to your health status.
2. Make it known whether course of treatment and what is expected of the patient is clearly understood.
3. Follow the treatment plan established by the physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
4. Provide a responsible adult to transport the patient home from the ambulatory surgery center and remain with the patient for 24 hours if required by the physician.
5. Keep appointments and notify the surgery center or physician when unable to keep an appointment.
6. Accept responsibility for any actions resulting from the refusal to follow treatment or physician's orders.
7. Accept and ensure that the financial obligations of care are fulfilled as promptly as possible.
8. Follow surgery center policies and procedures.
9. Be considerate of the rights of other patients and surgery center personnel.
10. Be respectful of personal property and that of other persons in the ambulatory surgery center.
11. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
12. Notify the staff if they have any safety concerns or feel their privacy is being violated.

NORTH ATLANTA
EAR, NOSE AND THROAT
SURGICAL CENTER

ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of North Atlanta ENT Surgical Center to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If you carrier is out of network, you are expected to pay at time of service, unless other arrangements have been made. I understand that my insurance company may send payments for the rendered service to me. I hereby assign North Atlanta ENT Surgical Center, all surgical, medical insurance and/or other benefits, if any, otherwise payable to me for the services. I agree to endorse the check(s) over to the surgery center. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to North Atlanta ENT Surgical Center from the obligor of said benefits. Further, I hereby assign and convey North Atlanta ENT Surgical Center, unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for North Atlanta ENT Surgical Center any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds. I understand that payment is due when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to the ASC. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with North Atlanta ENT Surgical Center be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

I have read or had this form read and/or explained to me and understand the contents of this document.

Patient/Guardian Signature: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____ Time: _____

Patient Name: _____