DATE _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH ____ / ____ / ____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

☐ OTHER _____

EMPLOYER _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

EMAIL _____

HOME PHONE (____) _____

WORK PHONE (____) _____

REFERRING PHYSICIAN _____

HOW DID YOU HEAR OF US? _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (____) _____

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (____) _____

WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____ COMPANY PHONE (____) _____

SUPERVISOR'S NAME _____ SUPERVISOR'S PHONE (____) _____

EMERGENCY CONTACT

SOCIAL SECURITY # _____ SEX _____

FIRST NAME _____ MIDDLE _____ HOME PHONE (____) _____

LAST NAME _____ WORK PHONE (____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH ____ / ____ / ____

RELATIONSHIP _____ DAYTIME PHONE (____) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____
SIGNATURE (Patient or Parent if Minor) DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____
SIGNATURE DATE

Angelina
Surgical
Associates

DARRY G. MEYER, D.O.

ALAN BASSIN M.D

GREGORY DeARMOND,M.D.

302 Medical Park Plaza Dr. Ste. 101
Phone (936) 634-8216

Lufkin Texas 75904
Fax (936) 634-8723

OFFICE POLICY

Our office is pleased to accept your insurance assignment on your surgery as soon as your exact coverage is verified. We will file your claim forms and assist you in every way we can. However, you are responsible for full payment according to your insurance policy, on your initial visit and any other offices on the day services are rendered. Follow up office visits for the first two weeks after surgery are non chargeable.

Office policy regarding insurance assignment:

(1) You must understand that the contract you have is between you and your insurance company and **you are fully responsible for any amount not paid by your insurance company.**

(2) Once your insurance remits payment, any balance will be due in full at that time. Arrangements must be made in advance for our office to agree to any other payment arrangements.

(3) Our office does not guarantee that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy and what it covers. However, if for some reason your claim is denied, **you are responsible for the full amount of your bill.**

(4) You are required to sign a statement authorizing the payment to be directly to our office.

(5) Our office will **not** enter into a dispute with your insurance company over the claim. This is your responsibility and obligation.

(6) **Delinquent accounts** will be turned over to a collection agency when deemed necessary.

(7) If for some reason you are unable to keep a scheduled appointment, we request that you notify us in advance.

By signing this statement, you are stating that you understand and agree to follow our office policy.

_____ SIGNATURE

_____ DATE

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read (or had the opportunity to read if I chose) and understood the preceding Notice of Privacy Practices of Angelina Surgical Associates containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

Patient Signature (or Authorized Signature)

Printed Name

Relationship of Authorized Signature to Patient

Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below;

Date	Initials	Reason

Last modified: 4/24/2003
177105.3

Listed below are person/s that have my permission to receive medical information regarding my health

Print Contact Name _____ Relationship _____

Print Contact Name _____ Relationship _____

Print Contact Name _____ Relationship _____

Your Rights

Access to Your Records

You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to you protected health information. You may also request access to your protected health information. If you also request copies, we will charge what the law allows. Contact us using the information listed at end of this notice for a full explanation of our fee structure.

Accounting of Disclosures

You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests

You have a right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communications

You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment of your Health Information

You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Contacts and Complaints

If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer in writing at the following address:

Angelina Surgical Associates
c/o Privacy Officer
P.O. Box 150507
Lufkin, Texas 75915

Or you may contact our Privacy Officer at our office location. If you have questions about this Notice, you may contact Angelina Surgical Associate's Privacy Officer by phone at 936-634-8216. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you if you make a complaint.

Our Promise to You

We have always respected your right to the privacy of your health information. This notice of privacy policy continues that tradition.

Marketing

We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities.

Research; Death; Organ Donation

We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety

We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect

We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration

We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity

Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law

We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon requests for purposes of determining whether we are in compliance with federal privacy information when authorized by worker's compensation or similar laws.

Process and Proceedings

We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances, such as a court order, warrant or grand jury subpoena; we may disclose your protected health information to law enforcement officials.

Law Enforcement

We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Angelina Surgical Associates
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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices and your rights concerning your protected health information. This notice takes effect April 24, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain. You may request a copy of our notice at anytime, please contact us by using the information listed at the end of this notice.

Treatment, Payment, Health Care Operations

Treatment

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We will also disclose protected health information to other physicians who may be treating you. In addition, we may disclose your protected health information to another physician or health care provider (a specialist or laboratory) or upon referral that at the request of your physician becomes involved in your health care diagnosis or treatment to your physician.

Payment

Your protected health information will be used, as needed, to obtain payment for your health services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility of coverage for insurance benefits, reviewing services provided to you for protected health necessary, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information to be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations

We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may share your protected health information with third party "business associates" that perform various activities (billing, transcription services, and consultants) for the practice.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures Based On Written Authorization

Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in your Health Care

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary in our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.