New Braunfels Spine and Pain Surgery Center

Acknowledgement of Review of Privacy Practices

I, the undersigned, have reviewed the New Braunfels Spine and Pain Surgery Center Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of the Privacy Practices.

✓_____ ✓_____

Signature of Patient or Representative Date

✓_____

Print Name of Patient or Personal Representative

_____

Capacity of Personal Representative (Parent, Guardian, Trustee, Executor)

✓_____

Address

✓_____

City, State, ZIP Code

Patient Label

HIPAA 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.

New Braunfels Spine and Pain Surgery Center
717 Generations Drive, Suite A
New Braunfels, TX 78130

If you have questions about this notice, please contact the person listed under "Whom to Contact" at the end of this notice.

SUMMARY

In order to provide you with benefits, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides if the Surgery Center receives personal information about your health, from you, you're physicians, hospitals, and others who provide you with health care services we are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

KINDS OF INFORMATION TO WHICH THIS NOTICE APPLIES

This notice applies to individually identifiable protected health information that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify the individual (hereinafter referred to as "protected health information").

POLICIES AND/OR RIDERS AFFECTED BY THIS NOTICE

The following policies and/or riders and any combination thereof, provided by the Surgery Center are subject to the privacy policies and procedures set forth in this notice: cancer insurance; medical expense insurance; health indemnity insurance; hospital indemnity insurance; dental insurance; long term care insurance; flexible health care spending accounts; Medicare supplement insurance, vision insurance; medical expense reimbursement plans; and any other coverages offered by us that meet the definition of a health plan contained in the HIPAA Privacy Rule.

The following policies and/or riders, and any combination thereof, provided by New Braunfels Surgery Center, and other coverages that do not meet the definition of a health plan contained to the HIPAA Privacy Rule are not covered under this notice: disability income insurance; accident only insurance; accidental death and dismemberment insurance; life insurance; annuity plans; Roth individual retirement accounts; simplified employee pension plans; and excess loss coverage on Self- Funded Health Plans.

WHO MUST ABIDE BY THIS NOTICE

All employees, staff, students, volunteers and other personnel whose work involves one of the products covered under this notice and who are under the direct control of New Braunfels Surgery Center must abide by this notice. The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of payment and operations activities as described below.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your protected health information.
- We are required to provide this notice of our privacy practices and legal duties regarding protected health information to anyone who asks for it.
- We are required to abide by the terms of the notice that is currently in effect

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any protected health information, which we already have, as well as to protected health information we receive in the future. Before we make any material change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all named insureds then covered by a product subject to the notice within 60 days of the effective date.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use your protected health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. **Payment**

   We will use your protected health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our claim-processing department may use your protected health information to pay your claims. We will also send you information about claims we pay and claims we do not pay (called an (explanation of benefits"). The explanation of benefits will include information about claims we receive for the Insured and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information Confidentially: see the "confidential Communication" section in this notice. We may also disclose some of your protected health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company with whom we contract to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

2. **Health Care Operation**.
   We may use and disclose your protected health information for activities that are necessary to operate this organization. This includes reading your protected health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may disclose your protected health information as necessary to others with whom we contract to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

3. **Legal Requirement to Disclose Information.**
   We may use or disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your protected health information, and the information of others, if we are audited by the state insurance department we will also disclose your protected health information when we are required to do so by a court order or other judicial or administrative process.

4. **Public Health Activities.**
   We will disclose your protected health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It also includes reporting certain information regarding products and activities regulated by the federal Food and Drug Administration. It may also include notifying people who have been exposed to a disease.

5. **To Report Abuse.**
   We may disclose your protected health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

6. **Government Oversight.**
   We may disclose your protected health information if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.

7. **Judicial or Administrative Proceedings.**
   We may disclose your protected health information in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).

8. **Coroners.**
   We may disclose your protected health information to coroners, medical examiners, and/or funeral directors Consistent with the law.

9. **Organ Donation.**
   We may use or disclose your protected health information for cadaveric organ, eye or tissue donation.

10. **Workers' Compensation.**
    We may disclose your protected health information to workers' compensation agencies if necessary for your Workers' compensation benefit determination.

11. **Limited Data Sets.**
    We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets.

12. **Research.**
    We may use or disclose your protected health information for research purposes, but only as permitted by law.

13. **Specialized Purposes.**
    We may use or disclose the protected health information of members of the armed forces as authorized by military command authorities. We may disclose your protected health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your protected health information for national security, intelligence, and protection of the president.

14. **To Avert a Serious Threat.**
    We may use or disclose your protected health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

15. **Family and Friends.**
    We may disclose your protected health information to a member of your family or to someone else that is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

MORE STRINGENT LAW

In the event applicable law, other than the HIPAA Privacy Rule, prohibits or materially limits our uses and disclosures of protected health information, as set forth above, we will restrict our uses or disclosure of your protected health information in accordance with the more stringent standards.

YOUR RIGHTS

1. **Authorization.**

   We may use or disclose your protected health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your protected health information for any other reason without your written authorization. If you authorize us to use or disclose your protected health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your protected health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of the notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the policy or the policy itself.

2. **Request Restrictions.**

   You have the right to request restrictions on certain of our uses and disclosures of your protected health information for insurance payment or health care operation, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your protected health information to your spouse. Your request must describe in detail the restriction you are requesting. We will consider your request. But we are not required to agree. We cannot agree to restrict disclosures that are required by law.

3. **Confidential Communication.**

   If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your protected health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your protected health information by mail. We will agree to any reasonable request. Requests for confidential communication must be in writing, it must state that the disclosure of the protected health information could endanger you; it must be signed by your or your representative, and sent to us at the address under "Whom to Contact" at the end of the notice.

4. **Inspect and Receive a Copy of Protected Health Information.**

   You have a right to inspect certain protected health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing, you must state that you are requesting access to your protected health information and either you or your representative must sign the request. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, or to receive a copy, contact us at the address under "Whom to Contact" at the end of this notice. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. **Amend Protected Health Information.**
You have the right to ask us to amend protected health information about you, which you believe is not correct, or not complete. If you want to request that we amend your protected health information you must make this request in writing, it must be signed by either you or your representative, and give us the reason you believe the information is not correct or complete. Your request to amend your information must be sent to the address under "Whom to Contact" at the end of this notice. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. **Accounting of Disclosures.**
You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your protected health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. To be considered, your accounting request must be in writing, signed by you or your representative and sent to the address under "Whom to Contact" at the end of this notice.

7. **Complaints.**
You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing, must describe the situation giving rise to the complaint and must be filed within 180 days of the date you know, or should have known, of the event giving rise to the complaint. You will not be subject to any retaliation for filing a complaint.

WHOM TO CONTACT:
Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

New Braunfels Spine and Pain Surgery Center
717 Generations Drive
Suite A
New Braunfels, TX 78130

Patient label

NEW BRAUNFELS SURGERY CENTER

CONDITIONS OF ADMISSION

AGREEMENTS, AUTHORIZATIONS, IRREVOCABLE ASSIGNMENTS

*Patient's Name*_____

Patient label

Admission Date _____

TERMS FOR RESPONSIBILITY

I understand that an admission deposit and/or verification of acceptable hospitalization insurance are required for admission to New Braunfels Surgery Center, (hereinafter referred to as "Surgery Center"). Total balance is due on discharge, with allowance made for insurance coverage approved and verified prior to discharge. However, I understand that in the event verified insurance benefits are not paid, for any reason, I will remain liable for all unpaid balances. Any exception to these terms must be agreed to by the Surgery Center before or at the time of admission.

FINANCIAL RESPONSIBILITY

In consideration for admitting the above patient for treatment. I/we assume full financial responsibility for the payment of all charges for services rendered. Payment is to be made to New Braunfels Spine and Pain Surgery Center, 717 Generations Drive, Suite A, New Braunfels, TX 78130, with settlement in full before departure of the patient.

WAIVER FOR VALUABLES

I understand the Surgery Center is not responsible for loss of, or damage to, personal effects, purses, dentures, property or valuables, including, but not limited to, rings, watches, furs, and money, unless same has been checked into the Surgery Center and a receipt issued. Property checked into the Surgery Center will not be6surrendered without a receipt.

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS AND CAUSES OF ACTION

In consideration of services rendered, I hereby irrevocably assign and transfer to the Surgery Center for myself and my dependents, all rights, title, and interest in the benefits payable for services rendered by the Surgery Center provided in any insurance policy(s) under which I or any of my dependents are insured. Said irrevocable assignments and transfer shall be for the purpose of granting the Surgery Center an independent right of recovery on any policy(s) of insurance to which benefits may be payable for this admission or medical services, but shall not be construed to be an obligation of the Surgery Center to pursue any such right to recovery. I further authorize direct payment to the physician/surgeon or any other provider who may have medical and/or surgical benefits applicable to my treatment.

I hereby authorize and direct all insurance company(s) under which I am insured, to pay directly to the Surgery Center all benefits due under said policy(s) by reason of service rendered therein. I will pay the Surgery Center for all charges incurred, or alternatively, for all charges in excess of the sum actually paid by said policy(s).

I also irrevocably assign to the Surgery Center all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance policy(s) under which I may be entitled to recover.

AUTHORIZATION TO RELEASE INFORMATION AND COMPLETE FORMS

I hereby authorize the Surgery Center to release any and all medical records, statements or any other information in connection with this admission, including, but not limited to, completion of claim forms on my behalf, in order to facilitate in the payment of medical bills incurred for this admission. I further authorize my employer or any other person, company or entity to release any information which may be necessary to determine the benefits payable under any insurance policy(s) which may provide coverage for this admission. I hereby agree to, and do, indemnify and release the Surgery Center for any and all responsibility or liability relative to the release of such information

AUTHORIZATION FOR TREATMENT

I hereby voluntarily consent to such medical care encompassing diagnostic procedures and medical treatment by the physician or physicians in charge of the case, their assistants and designees as necessary in their judgement, and employees and agents of the Surgery Center.

PATIENT'S CERTIFICATION, AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to New Braunfels Surgery Center.

DECLARATION

I certify that I have carefully read, understand and agree to the above terms, agreements, authorizations, and irrevocable assignments, and any questions have been fully answered.
A photocopy of this document shall be considered as effective and valid as the original.

✓PATIENT _____ ✓WITNESS _____

✓RELATIONSHIP TO PATIENT _____ ✓DATE OF SIGNING _____

NOTE TO INSURANCE COMPANY: *A COMPLETE COPY OF THIS FORM MUST BE FORWARDED TO New Braunfels Spine and Pain Surgery Center MEDICAL RECORDS FOR ADDITIONAL MEDICAL INFORMATION.*

PATHOLOGY, PHOTO, BLOOD TEST, VIDEO-TAPING , VIEWING

I, the undersigned, do hereby authorize and direct New Braunfels Surgery Center and/or the pathologist to care for or otherwise dispose of any tissue. I give my consent to any photographing or video taping deemed necessary by my surgeon. I understand these photographs are the property of my surgeon. I give my consent to view for person and/ or persons designated by my surgeon.

I also consent to the withdrawal of a blood sample for (included but not limited to) HIV (AIDS) and the hepatitis in antibodies. I understand that the blood test(s) will be done only if any employee or physician has had an accidental needle stick or mucous membrane exposure to my blood or body fluid. Also, I understand that this is being done on the order of my physician and the results will be released to him/her. I authorize the release of any appropriate data necessary to process the testing and the insurance claim which New Braunfels Surgery Center will file. I understand there will be no further cost to me for this blood test.

✓Initials _____

GENERALANESTHESIA INFORMATION/IV SEDATION

I understand that I am not to drive a motor vehicle, operate machinery, consume alcoholic beverages, sign legal documents or take medication other than those prescribed by my doctor for twenty-four (24) hours following administration if general anesthesia. Also, I have been advised it is best to have someone with me for at least twenty-four (24) hours following surgery.

✓Initials _____

MEDICAL RECORDS RELEASE

This authorization is to obtain or release information that is pertinent to my medical care. This authorization will expire 180 days from the date it is signed, and may be revoked by the patient or patient's legal guardian at any time. The information will be utilized for the purpose of professional uses by an authorized physician.

✓Initials _____

NPO STATUS STATEMENT

I certify that I (my child), as recommended by my physician, have (has) had: Nothing

to eat or drink, including water, since midnight.

No alcoholic beverages to drink in 24 hours.

Nor has there been any change in my physical status such as a cold or infection.

✓Initials _____

FINANCIAL STATEMENT

I understand that any copay or financial responsibility is for the Surgery Center Facility Fee only. It does not include the Physician's or Anesthesia Fee. Those are billed separately by their office.

✓Initials _____

_____ _____

✓PATIENT/LEGAL GUARDIAN SIGNATURE ✓WITNESS SIGNATURE/DATE

Patient Label