Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

I **understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Mesquite Surgery Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Mesquite Surgery Center has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Mesquite Surgery Center will provide me with the most current *Notice of Privacy Practices*.

My signature indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Mesquite Surgery Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Mesquite Surgery Center has taken action relying on this consent.

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Mesquite Surgery Center, 7445 East Tanque Verde Road, Tucson, Az., 85715. 520-722-0929.

TERMS AND CONDITIONS OF SERVICE

The patient named on this form is admitted to Mesquite Surgery Center (MSC) for outpatient treatment subject to the following terms and conditions.

1. Consent for Treatment. I wish to receive medical care and treatment at the MSC. Accordingly, I consent to the procedures, which may be performed during this MSC visit, including emergency treatment. I authorize and consent to any of the following: laboratory procedures, other diagnostic procedures, medical or surgical treatment, or other clinical and hospital services as directed by my physician(s) or my physician's(s) assistants, which my physician(s) believes are advisable to evaluate or treat me, and to other services rendered under the general and special instructions of my physician(s). I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that this MSC has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. Disclosure of Information for Payment Purposes. I understand my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at MSC.

3. Information to Other Providers. I understand that in the course of my treatment and/or making arrangements for my care, my information may be shared with other providers. If I prefer that this MSC not use or share my information, I may submit a written request for consideration per MSC's Notice of Privacy Practices. I authorize reports of my evaluation, treatments, and any follow up evaluations be sent or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician, as well as any other healthcare providers, pathologist, hospitals, or outpatient facilities and that I have or will identify to you. I permit a copy/fax of this form to serve as an original signature of authorization.

4. Non-Discrimination Policy. MSC will admit and treat patients within its capabilities regardless of race, color, national origin, religious beliefs, sex, sexual orientation, marital status, veteran's status, age, political beliefs, or disability.

5. Financial Agreement. I understand that I will receive a bill from MSC. The physician(s) will bill me separately for their services provided to me while at MSC. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of MSC. I understand that I may also receive a separate bill from the pathologist and anesthesia for services rendered. MSC reserves the right to charge a Late Payment Fee and/or a Returned Check Fee. If I choose to pay all charges myself, I will notify MSC prior to receiving service. Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency. . **PLEASE NOTE: You will be charged $100 (physician fee) and $250 (facility fee) for any procedure that is not cancelled within 48 hours unless there are unforeseen circumstances.**

6. Medicare Coverage (if applicable). I certify that the information I have been given in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to MSC. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to MSC for any services provided to me by MSC.

7. Assignment of Benefits. I hereby authorize assignment of my medical insurance benefits to MSC for payment to the bill for medical services I received. I further authorized MSC to receive direct payment from my insurance company or third party payer. I agree to remain responsible and liable for payments of all amounts due MSC not received from my insurance carrier(s). I understand MSC is submitting claims on my behalf as a courtesy. I authorize Anesthesia Associates of Tucson LLC, to apply for benefits on my behalf and authorize payment from my health insurance carrier related to anesthesia services rendered.
I SHALL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

8. Personal Valuables. I understand MSC discourages patients from bringing their valuables and other personal property to MSC. I will not hold MSC liable for any loss or damage to valuable kept in my possession.

9. Patient's Rights and Responsibilities. My signature below confirms that I have received the information on MSC's Patient Bill of Rights and Responsibilities as a patient.

10. Ownership Disclosure. Miguel A. Arenas, MD is one of the owners of MSC. My signature below confirms that I am aware of his financial interest in MSC. I have a right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

11. ACKNOWLEDGEMENT OF RECEIPT OF THIS MEDICAL FACILITY'S NOTICE OF PRIVACY PRACTICES. I have received and or offered a copy of this facility's **NOTICE OF PRIVACY PRACTICES.**

12. ADVANCE DIRECTIVES. I acknowledged that I have been provided an opportunity to disclose and discuss any Advanced Directives I have established. I also understand that during my outpatient stay at Mesquite Surgery Center every attempt to comply with these directives will be made by my health care team. My care and interventions will be based on my individual needs and plan. If, during my stay, my condition deteriorates or I experience a life threatening emergency my health care team would always attempt to resuscitate me and transfer me to a local hospital. If I have provided a copy of my Advanced Directives it will be transported with me.

I have read this consent and I am the patient, or the patient's duly authorized representative. On my own behalf (or on the behalf of the patient), I accept and agree to be bound by all of these TERMS AND CONDITIONS OF SERVICE.

Patient Signature____________________________

Witness Signature____________________________

Date____________________________