SURGICAL SPECIALISTS, INC.

PATIENT INFORMATION

FULL LEGAL NAME: DATE OF BIRTH: SOCIAL SECURIT Y #:

ADDRESS: CITY: STATE: ZIP CODE:

AGE: SEX: MARITAL STATUS: EMPLOYER: WORK PHONE:

HOME #: CELL #: E-MAIL ADDRESS: DRIVERS LICENCE#

SPOUSE/RESPONSIBLE PARTY INFORMATION

FULL LEGAL NAME: DATE OF BIRTH: HOME NUMBER:

ADDRESS: (IF DIFFERENT THAN ABOVE)

EMPLOYER NAME: CITY: STATE: ZIP CODE: BUS PHONE:

EMERGENCY AND OTHER INFORMATION

PERSON TO CONTACT IN CASE OF EMERGENCY: RELATIONSHIP

REFERRING DOCTOR: (NAME AND NUMER) OTHER DOCTORS YOU SEE:

IMPORTANT INFORMATION

Patient with contract health plans, please present your insurance ID card to the receptionist after completing this form. Some contract health plans (HMO'S, PPO'S, ect.) require a co-payment at the time of service. Most contracted health plans require that the claim be submitted by our office. If you have any questions we will, be happy to assist you. I hereby assign all health insurance benefits to be paid directly to Daniel Oh MD, Han Soo Kim MD, Joseph Centeno M.D. & Thomas Bosshardt M.D. **I understand that I am ultimately financially responsible for non-covered services.** I also authorize the release of my medical information as necessary to process medical claims on my behalf.

PATIENT SIGNATURE **DATE OF SIGNATURE**

HIPPA Notice of Privacy Practices

Thomas Bosshardt, M.D. Joseph Centeno, MD Daniel S. Oh, MD Han Soo Kim, MD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Private Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physically or mental health or condition and related health care services.

1. Uses and Disclosure of Protected Health Information.

Uses and Disclosures of Protected Health Information.

Your protected health information may be used and disclosed by your physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other use required by law.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage you're health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission

Healthcare Operations. we may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. The activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Over sight: Abuse or Neglect: Food and Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organs Donation: Research: Criminal Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You're Right

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health Information Under federal law; however, you may not inspect or copy the following records: psychotherapy notes; Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

HIPPA Notice of Privacy Practices

You have the right to request a restriction of your protected health information, this means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you may want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to receive confidential communications from us by alternative means of at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right t change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provide in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contacts of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes affective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

IMPORTANT INSURANCE AGREEMENT:

Patients with the contract health plans, please present you insurance ID card to the receptionist after completing this form. Some contract health plans (HMO's PPO's, IPA's, ect.) require a co-payment at the time of service. Most contracted health plans require that the claim be submitted by or office. If you have any questions we will, be happy to assist you. I hereby assign all health insurance benefits to be paid directly to Surgical Specialist's, Inc. I understand that I am ultimately financially responsible for non-covered services. I also authorize the release of my medical information as necessary to process medical claims on my behalf.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

SURGICAL SPECIALISTS, INC.

Dear Patient,

Please be advised that Surgical Specialists, Inc. may or may not be a participating provider group with your insurance company. Please check with your current insurance carrier to insure we are a contracted provider.

Surgical Specialists, Inc. does not take responsibility in educating or advising patients as to contracted or non-contracted insurance companies and or their covered services.

If we are participating providers with your insurance company, and we have been issued an authorization to treat you, will be bill your insurance company for services. If for any reason your insurance company does not pay any portion of your bill, you may be responsible for the remainder of your bill.

If your eligibility or coverage is not current, you will be financially responsible for the entire bill.

Please be advised that any services which are not covered under your current insurance carrier, will be your financial responsibility to pay. It is also your responsibility to know what is and is not a covered service.

If you are currently uninsured, payment for services will be due at the time of service.

If you have any questions about our policy, feel free to ask for the Office Manager and you will be assisted with an explanation.

Sincerely,

SURGICAL SPECIALISTS, INC.

Patient or Guardian's Signature **DATE**

I acknowledge that I have read and understand that this is a legal financial disclosure.