PEDIATRIC SURGICAL ASSOCIATES, LTD.

TO OUR PATIENTS: We desire to maintain an open and direct relationship with our patients, both in matters of health and finance. Please read and sign the form below. If you do not understand it, please ask questions.

PATIENT CONSENT AND HIPAA POLICY: As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. We have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give consent, at any time you may request to refuse disclosure of your PHI. You may not revoke any actions that have already been taken which relied on this or a previously signed consent.

The use and disclosure of Protected Health Information include, but are not limited to the following: treatment services, payment for health care services, healthcare operations, permission to view patient's prescription history from external sources, and to payer network organizations, including clinically integrated networks and/or accountable care organizations we participate in, for quality assessment and improvement activities. Other permitted and required uses and disclosures will be made only with your consent, unless required by law.

For more information see our Notice of Privacy Practices, available at the front desk. If you have any questions regarding the HIPAA policy, please ask to speak to our HIPAA Compliance Officer.

ONE TIME ACKNOWLEDGEMENT: I acknowledge that I have been provided a copy of Pediatric Surgical Associates privacy practices. If I would like a copy in the future, I will ask for one.

INITIALS _____

PATIENT CREDIT POLICY: Accounts are payable upon receipt of the first statement, or as required by the practice.

I agree to pay for any charges not covered by my insurance.

INITIALS _____

PATIENT PORTAL ACKNOWLEDGEMENT: I acknowledge that I have been provided a copy of PSA's Portal Guidelines.

INITIALS _____

METHOD OF COMMUNICATION: I agree to allow the use of encrypted email to exchange certain medical information with Pediatric Surgical Associates. If I would like more information on the technology that is used, I will request it.

INITIALS _____

REFERRAL REQUIREMENTS: Many insurance plans require a referral from one's primary care physician. If your insurance plan requires a referral, please contact your primary care physician or your insurance company.

INITIALS _____

_____	_____	_____
Date	Patient or Authorized Signature	Relationship to Patient

_____	_____
Patient Name	D.O.B.