

Provincial Park Surgery Center
21300 Provincial Boulevard, Ste. 200
Katy, Texas 77450

Patient Label

Patient's Bill of Rights and Responsibilities

- I. A patient has the right to respectful care given by competent personal.
- II. A patient has the right, upon request, to be given the name of his attending practitioner, the names of all other practitioners directly participating in his care and the names and functions of other health care persons having direct contact with the patient.
- III. A patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.
- IV. A patient has the right to have records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangement.
- V. A patient has the right to know what Facility rules and regulations apply to his conduct as a patient.
- VI. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
- VII. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
- VIII. The patient has the right to full information in layman's terms, concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the responsible person.
- IX. Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of a procedure. Informed consent is defined in Texas Administrative Code, Title 25, Part 7, Chapter 601.
- X. A patient or, if the patient is unable to give informed consent, a responsible person, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program, and the patient, or responsible person, shall give informed consent prior to actual participation in the program. A patient, or responsible person, may refuse to continue in a program to which he has previously given consent.
- XI. A patient has the right to refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.
- XII. A patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sexual orientation, national origin, handicap, disability or source of payment.
- XIII. The patient who does not speak English shall have access, where possible, to an interpreter.

- XIV. The Facility shall provide the patient, or patient designee, upon request, access to the information contained in his medical records, unless access is specifically restricted by the attending practitioner for medical reasons.
- XV. The patient has the right to expect good management techniques to be implemented with the Facility. Those techniques shall make effective use of the time of the patient and avoid the personal discomfort of the patient.
- XVI. When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.
- XVII. The patient has the right to expect that the Facility will provide information for continuing health care requirements following discharge and the means for meeting them.
- XVIII. A patient has the right to be informed of his rights at the time of admission.
- XIX. The Facility expects the patient to ask questions about any directions or procedures they don't understand.
- XX. The Facility expects the patient to be considerate of other patients and staff in regard to noise, smoking, and number of visitors in the patient areas. The patient is also expected to respect the property of Facility and other persons.
- XXI. The patient is expected to follow instructions and medical orders and report unexpected changes in their condition to their physician and facility staff.
- XXII. The patient is expected to follow all safety regulations that they are told or read about.
- XXIII. If the patient fails to follow their healthcare provider's instructions, or if the patient refuses care, they are responsible for their own actions.
- XXIV. The patient can choose to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.
- XXV. Patient has the right know of physician's financial interest in the surgery center
- XXVI. Patient has the right to ask the surgery center to honor their Advance Directive
- XXVII. The patient has the right to be free from all forms of abuse, neglect, or harassment.

The physicians, nurses and the entire staff at Provincial Park Surgery Center committed to assure you reasonable care. Should you have a complaint or grievance related to Provincial Park Surgery Center, contact the Administrator at 713 554-6350.

Medicare Beneficiary Ombudsman: Visit the Ombudsman's webpage at www.cms.hhs.gov/center/ombudsman.asp Call 1-800-MEDICARE (1-800-633-4227) to get their telephone number. TTY users should call 1-877-486-2048.

If your complaint or grievance is not resolved to your satisfaction, you may contact The Department of State Health Services, Facility Licensure and Certification, Texas Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756, (888) 973-0022. Presentation of a complaint will not compromise your care under any circumstances.

Patient's Signature

Date

Witness Signature

Date

PROVINCIAL PARK SURGERY CENTER

Consent to Medical Care: I request admission to Provincial Park Surgery Center and authorize the facility, staff and physicians to provide care. I request and consent to medical care and diagnostic procedures that my attending physician(s), or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in Provincial Park Surgery Center is under the direction of my attending physician(s) and that Provincial Park Surgery Center is not responsible for acts of omission of my attending physician(s). I authorize Provincial Park Surgery Center to retain or dispose of any specimen or tissue taken from the above named patient.

Teaching Programs: I understand that this facility is a facility that promotes education opportunities, and therefore, I understand that I may be seen and examined by supervised participants as a part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at any time.

Disclosure of Information: The undersigned agrees that all records concerning this patient's admission shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that **THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

Special Consent for HIV Testing: The undersigned specifically consents to the testing of the patient's blood or human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, its expected benefit, and has been given the opportunity to ask questions about the blood test.

☐ Do ☐ Do Not I (we) authorize Provincial Park Surgery Center and/or my physician to photograph/video or permit other persons to photograph/video for such purposes as may be deemed necessary.

☐ Do ☐ Do Not I (we) consent to the presence of students, residents or fellows, and vendors in the operating room to observe the procedure. I am aware that only the physician may grant this permission on my consent.

Advance Directives: Provincial Park Surgery Center does not follow any predetermined Advanced Directives. If you have any questions please talk to your physician or anesthesiologist.

Patient Rights: I acknowledge receipt of information explaining my rights as a patient and, on request, I received a copy of the State notice and this facility policy statement regarding Patient's Right to Self-Determination.

I have been informed that my physician may be a partner in ownership of Provincial Park Surgery Center I have the right to review a list of partners. The Physicians and Allied Health Professionals (AHPs) practicing at Provincial Park Surgery Center are licensed and/or credentialed to practice in this facility. The physicians and AHPs provide medical services at Provincial Park Surgery Center, but they are not agents or employees of Provincial Park Surgery Center.

Financial Agreements: For services hereto performed or to be performed for the Patient by Provincial Park Surgery Center (whether one or more), below signed (severally if more than one), whether as patient, agent or guarantor, agrees and promises to pay the charges for the care so provided to the Patient by Provincial Park Surgery Center in accordance with Provincial Park Surgery Center then current standard rates and all costs incurred in collecting same, together with attorney's fees, which Provincial Park Surgery Center deems necessary and reasonably required to enforce the rights of Provincial Park Surgery Center. Prior to the patient's scheduled procedure insurance verification was performed and an estimate of patient's responsibility was calculated. The patient acknowledges that these charges are an estimate only and could change based on actual procedures performed by the surgeon on time/supplies used.

Consent for Admission and Treatment*Place Patient Sticker Here*

Assignment of Insurance Benefits to Provincial Park Surgery Center. As or on behalf of the Insured under the insurance specified on the registration documents of the patient, and otherwise payable thereto (the present and future rights thereto and monies due or to become due there from termed "Contract Rights"), the below signed irrevocably assigns and transfers to Provincial Park Surgery Center the Contract Rights, and orders and directs such insurer(s) to pay all monies due or to become due thereunder directly to Provincial Park Surgery Center or its assignee. To effect such payment, Provincial Park Surgery Center is irrevocably constituted and appointed lawful attorney in fact with substitution power, to sue or otherwise collect and settle any claim under the Contract Rights as insured without further notice or approval of Insured and to endorse in the name of the Insured any check or other instrument for the payment of monies thereunder.

Furthermore, the below signed, whether as patient, agent or guarantor, hereby designates Provincial Park Surgery Center as its authorized representative and assigns to Provincial Park Surgery Center all rights to pursue reimbursement, pursue appeals, engage in litigation and pursue breach of fiduciary duty causes of action.

Further, I understand that **ANESTHESIOLOGY, PHYSICIAN SERVICES, PATHOLOGY, RADIOLOGY, MONITORING, and some LABORATORY SERVICES** will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize Provincial Park Surgery Center to release my medical information needed by my insurance carrier to process the claim.

If Insured receives monies directly from the Insurer(s), same shall be held in trust and immediately transferred to Provincial Park Surgery Center for amounts due. This assignment is irrevocable with interest until full and complete payment of all monies due to the Facility and its affiliates from this event of admission or otherwise. Money received by Provincial Park Surgery Center from Insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered to the Patient. If charges not covered by insurance cannot be paid in full when due, below signed agrees upon request to sign a promissory note bearing interest at the maximum legal rate to pay all debt not paid, if credit is approved.

Unborn Child Coverage: If pregnant, the above consent for treatment, releases, assignments, and guarantor agreement apply to my newborn child if born at this facility during this period of treatment.

Insurance Precertification: I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Medicare Assignment, Patient's Certification, Authorization to Release Information and Payment Request:

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 be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Acknowledgement of Notice of Privacy Practices: A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admissions packet and posted in the Facility. By signing below you acknowledge that you have received a copy of the Facility's Notice of Privacy Practice.

I GIVE PERMISSION for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. ☐ **Yes** ☐ **No**

☐ **Limited disclosure to persons listed below:**

Name: _____

Name: _____

Name: _____

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS "CONDITIONS OF ADMISSION AND TREATMENT" FORM.

PATIENT

SIGNATURE: ☒ _____ **Date:** _____

WITNESS: ☒ _____ **Date:** _____

Patient (is a minor _____ years of age) OR is unable to consent because: _____

Relative / Authorized Agent _____

Relationship to Patient: _____ **Date:** _____

REGISTRATION

Date _____ Home Phone _____ Work Phone _____ Email _____
 Patient Last Name _____ First Name _____ Initial _____
 Street Address _____
 City _____ State _____ Zip _____
 Sex: ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
 Social Security # _____ Driver's License # _____
 Insured Name _____ How and where did you learn about this clinic? _____
 Last Name First Name Initial

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ ☐ Full-time ☐ Part-time City _____ State _____ Zip _____ Years Employed _____
SPOUSE (PARENT)	Name _____ Birthdate _____ SSN: _____ Last Name First Name Initial Employer Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State _____ Zip _____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No Your Initials: _____ If you answered yes, please take this form back to the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone: _____ Address _____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	Legal Assignment of Benefits And Designation Of Authorized Representative In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), <u>as my designated Authorized Representative(s)</u>, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. <u>I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA.</u> I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ Signature of Insured / Guardian _____ Date

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Effective Date: _____

Insurance Carrier: _____

Policy I.D Number: _____

Patient Signature: _____

Patient Name Printed: _____

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. We require that you read and sign this policy to any treatment received.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

All patients must complete our Patient Registration forms before receiving treatment.

WE ACCEPT CASH, CASHIERS CHECKS, AND CREDIT CARDS.

PLEASE READ AND INITIAL EACH PARAGRAPH:

_____ ALL INSURANCE PATIENTS: Many insurance companies have informed us that they will be sending all payments directly to the patients. If you receive any payments or checks from your insurance company for any portion of your care please notify us immediately. If you do not return the check and a copy of the explanation of benefits to us then we will hold you financially responsible for the full balance billed by the facility. If you receive a check from your insurance company, please contact us at 713-554-6350 for further instruction. Failure to contact us upon receipt of payment/check, will result in immediate collections and possible legal fees.

_____ IN-NETWORK BILLING: **Provincial Park Surgery Center** in-network with only a few insurance companies. Please check with us to see if your plan is in or out-of-network.

_____ OUT-OF-NETWORK BILLING: **Provincial Park Surgery Center** is out-of-network with most insurance providers. If you have any questions regarding your financial responsibilities please ask to speak with our financials/ billing office.

_____ USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

_____ MINOR PATIENTS: The adult accompanying a minor and the parent/guardian of the minor is responsible for full payment. For unaccompanied minors, all non-emergency treatment will be denied unless charges have been pre-authorized by the Financial Counselor or paid by check or credit card at the time of service.

_____ OTHER SERVICES/PROVIDERS: You will be held financially responsible for all charges accumulated from other services and providers. (i.e. labs, anesthesia services, etc.) A list of the providers can be available by request. Payment towards anesthesia services will be accepted at and by **Provincial Park Surgery Center**. I understand that my physician may have ownership in this surgery center.

_____ DOCUMENT FEES: To receive Medical Records a request must be made in writing and charges paid before receipt of records is made.

_____ MUA PATIENTS: As an MUA patient you are held to the financial policy discussed to you by your physician or physician's office representative. If you have any further questions please talk to our center about an Assignment of Benefits form.

Please let us know if you have any questions concerning our Financial Policy.

NOTES: _____

Patient Signature

Date



INTEGRATED HEALTH SERVICES
Optimal Healing Through Quality Care

**Affordable Care Act (ACA) Discount Disclosure:
You Are Protected From Any Unexpected Costs and Bills**

PROVINCIAL PARK SURGERY CENTER, LLC

Dear Patient:

1. As your Patient Advocate (PA), we offer the highest care quality and safety possible at the **most affordable cost to you**, no matter if you are covered by an in-network or out-of-network health plan.
2. We offer an **Affordable Care Act Discount (ACA Discount)** under our Corporate Compliance Policy to anyone who qualifies, on a case by case basis. **You only pay what you can afford or are willing to pay** for your deductible and co-insurance, as outlined in your plan cost-sharing obligations, based on your medical need. Most people may qualify and **your satisfaction is guaranteed**.
3. Our Affordable Care Act (ACA) Discount is **similar to or even much better than all PPO discounts**, as our **ACA Discount is available from both in-network and out-of-network providers and facilities**.
4. Once you qualify, **you will NOT receive ANY unexpected invoices, bills or collection letters FROM US**, even if your insurance denies your claims.
5. As your Patient Advocate and Authorized Representative, and under the new federal health reform law PPACA (Patient Protection and Affordable Care Act, or ACA), we may appeal all of the claim denials or delays on your behalf, which is strictly in compliance with the new federal health reform law, PPACA.
6. As your Patient Advocate, **your best interest is our best interest**. To ensure that you also get this kind of ACA Discount from other providers known to us or affiliated with us, we will inform you of these facilities and/or providers, **so you may also receive the best care possible along with the ACA Discounts and Savings**.
7. With your informed choice, we will refer you to a provider who may also offer a compliant ACA Discount and ensure that **you are always protected from any unexpected costs and bills** under the new federal health reform law (PPACA).
8. As your Patient Advocate, we want **you to be fully protected from any unexpected costs and bills from any providers, unless otherwise authorized by you**.
9. You always have freedom of choice to receive healthcare from any provider you choose. However, we can not speak for or guarantee anything on behalf of other providers we don't know or are not affiliated with regarding their discount or collection policies. You are advised to contact them directly before scheduling your next appointment(s) or medical procedure(s).
10. **If you are willing to be protected from any unexpected costs and bills**, feel free to apply for our Affordable Care Act Discount under our Corporate PPACA Indigency Policy. **"Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount"**. Your satisfaction is guaranteed.

I have read and fully understand this Patient Protection & Advocacy Policy. My questions are fully answered.

Patient Name (print)

Signature of Patient

Date



INTEGRATED HEALTH SERVICES
Optimal Healing Through Quality Care

Provincial Park Surgery Center, LLC

Patient Name: _____ Plan No.: _____

Insured Name: _____ Insured ID: _____

Our indigency discount is no different than all PPO discounts from BCBS or all other commercial insurers in compliance with all applicable federal and state laws with respect to indigency assistance without any routine waiver of cost sharing, advertising, or solicitation, for underinsured or uninsured patients. **Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount** without waiving any patient financial and legal obligation or responsibility to the provider's actual total charges AND patient's right and eligibility, assigned to the provider, to claim for the reimbursement, under the health plan coverage, based on the provider's actual total and reasonable charges in accordance with Provider's Corporate Indigency Policy, **as the indigency determination itself is a good effort to collect**, and hospitals or doctors are NOT required under any federal or state laws, Medicare, ERISA & PPACA, to take low-income, medically indigent, uninsured or underinsured patients to court, garnish their wages, or seize their homes, or send claims out to a collection agency when those patients don't or can't pay their hospital or doctor bills. New federal Affordable Care Act (ACA) laws protect **middle class** and **low income** Americans with ACA Indigency Discount.

In consideration of my particular medical needs and care expenses to be incurred solely based on such medical needs, and my financial ability to pay for such recommended medical services without or even with applicable insurance coverage, and with understanding and agreement that I am personally financially and legally obligated to and responsible for any and all professional actual total charges regardless of any applicable insurance coverage, **I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:**

Middle class income, with high deductible / co-insurance, as medically indigent (see CMS Definition below)

Middle class income, Cash Pay - without any or applicable insurance for treatment from this provider / facility

Low or a fixed income, with financial hardship, as financially indigent

More importantly, I declare that without following indigent assistance, seeking for and continuing with medically appropriate and important health care would be impossible for me or would make me indigent if I were forced to pay full charges for my medically necessary care expenses. I also declare that I personally requested for such indigent assistance only after I was fully informed of my important medical treatment options and necessity solely based on my particular medical needs and availability of this provider Indigency Policy. **Without my expressed permission, NONE of my private financial information or documents may be released to any 3rd party TPA, except for this Indigency Agreement or only medical information as requested by my health plan / TPA.**

"Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a healthcare provider from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the healthcare provider indigence policy."

*"By **'indigency policy'** we mean a policy developed and utilized by a healthcare provider to determine patients' financial ability to pay for services. By **'medically indigent'**, we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses."*

I specifically request under this provider indigency policy for the following indigent discount assistance for the specific time periods from _____ to _____, after determining in good faith that I am in financial need or after reasonable collection efforts failed.

Waiving collection of deductible _____

Waiving collection of co-insurance _____

Waiving collection of co-pays/encounter fees _____

Waiving collection of total cost-sharing _____

I can only afford to pay _____ for my total balance

I am only willing to pay monthly for a total of _____

Attempts to Collect

Patient's Signature _____ Date _____

1: _____

Staff Signature _____ Date _____

2: _____

3: _____

Date: _____

Plan Sponsor' address (Subscribers Employer's address):

As a beneficiary for Policy I.D. #- _____ Group- _____
(Member) _____

I hereby request a complete copy of the governing plan documents, **Summary Plan Description (SPD) & 5500 Form (Plan Annual Return) Request**. More importantly, for the purposes of applicability of compliance with PPACA, I specifically request from you a **Certified Copy of Certificate for PPACA Grandfathered Plan**.

Please send to: 6351 Preston Road, Suite 295,
Frisco, TX 75034

Patient Signature: _____ **Date:** _____

Any plan fiduciary's refusal or neglect to provide the SPD upon timely receipt of notice (without disclosing of his/her specific reason for denial of such SPD request or non-fiduciary status) will be deemed to have performed a de facto plan administrator's SPD duty as specified in ERISA. This request is made under ERISA § 502 (c), 29 USC § 1132 (c) & ERISA § 511, 29 USC § 1141, as referenced specifically and contained in this Notice of Legal Assignment of Benefits and SPD request. Furthermore, should this ERISA plan contain an unambiguous anti-assignment clause prohibiting assignment of rights, benefits and causes of action in SPD, the plan administrator is required to timely notify or disclose to the assignee of such prohibition by disclosing such SPD, especially on this appeal process, to avoid judicial unenforceability of your anti-assignment clause on judicial process. (Hermann Hosp. v. MEBA Medical and Benefits Plan)

HIPAA PERSONAL PRIVACY CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing the Consent and you are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received and reviewed this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practice to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via e-mail, U.S. Mail, telephone, fax and/or pre-recorded messages. We will not ever sell or SPAM your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time, and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

In order to maintain your personal privacy, we would like to retain the following information on file to serve as a **Personal Privacy Act**. This document will stay in effect until the Patient replaces it with an updated form.

1. May a representative from our office leave you a voice mail? ☐ YES

☐ NO

If yes, please indicate which number is preferable: Home / Cell

Ph#: _____

2. Is there anyone with whom we may speak in your absence? ☐ YES

☐ NO

If yes, please indicate

Name _____

Number (if not previously listed) _____

HIPAA PERSONAL PRIVACY CONSENT FORM

SIGNATURE PAGE

Printed name _____

Signature _____

Date _____

Relationship to the patient _____

Witness Name _____

Witness Signature _____

Date _____

For Internal Use

Patient Refused to Sign

Patient Unable to Sign

PROVINCIAL PARK SURGERY CENTER, LLC
21300 Provincial Blvd, Suite 200 Katy, TX 77450 Ph: 713-554-6350 Tax ID: 61-1661162

FACILITY FEES & SERVICE AGREEMENT

DO NOT SIGN THIS CHARGE TICKET AND SERVICE AGREEMENT UNLESS YOU UNDERSTAND IT COMPLETELY!

Patient Name: _____ **SSN/DOB:** _____ **Date of Surgery:** _____
Attending Surgeon: _____ **Anesthesiologist/CRNA:** _____ **Facility Staff Signature:** _____

FEE SCHEDULE DISCLOSURES - CHARGES YOU ARE OBLIGATED TO PAY AND HAVE BEEN BILLED FOR TODAY

Primary Surgery	CPT	Fee	Primary Surgery	CPT	Fee	Insurance Verification / Precertifications
☐ Cervical Facet Inj - 1st level	64490	\$ 4,430.00	☐ RF of Cervical Facet Joints - add joints	64634	\$ 2,909.00	☐ In-Network
☐ Cervical Facet Inj - 2nd level	64491	\$ 2,109.00	☐ RF of Lumbar Facet Joints - single joint	64635	\$ 5,454.00	☐ No Insurance Coverage
☐ Cervical Facet Inj - 3rd & add	64492	\$ 2,091.00	☐ RF of Lumbar Facet Joints - add joints	64636	\$ 3,323.00	☐ Out-of-Network
☐ Lumbar Facet Inj - 1st level	64493	\$ 4,414.00	☐ Inj - Destruction by Neurolytic Agent	64600	\$ 8,088.00	☐ Precertification #: _____
☐ Lumbar Facet Inj - 2nd level	64494	\$ 2,091.00	☐ Inj Lg Joint/Bursa - Shoulder, Hip, Knee	20610	\$ 3,140.00	Date: _____
☐ Lumbar Facet Inj - 3rd & add	64495	\$ 2,062.00	☐ Injection Med Joint - Wrist, Elbow, Ankle	20605	\$ 2,597.00	Payment Arrangements
☐ Cervical Transforaminal Inj - single level	64479	\$ 6,407.00	☐ Injection - Tendon Sheath/Ligament	20550	\$ 658.00	☐ Pay total charges each visit.
☐ Cervical Transforaminal Inj - add level	64480	\$ 1,771.00	☐ Injection-Trigger Points(s), 1-2 Muscles	20552	\$ 1,570.00	☐ Pay Co-Pay and/or Deductible each visit.
☐ Lumbar Transforaminal Inj - single level	64483	\$ 5,038.00	☐ Injection -Trigger Points(s), 3+ Muscles	20553	\$ 1,216.00	☐ Pay \$_____ per _____ until balance is paid.
☐ Lumbar Transforaminal Inj - add level	64484	\$ 2,080.00	☐ Injection - Discography	62290	\$ 3,734.00	☐ Pay total outstanding charges before treatment next visit.
☐ Cervical/Thoracic Epidural Inj	62310	\$ 3,156.00	☐ Injection - Hip Arthrogram	27095	\$ 2,745.00	☐ PPO Arrangement
☐ Lumbar/Caudal Epidural Inj	62311	\$ 2,342.00	☐ Injection - Knee Arthrogram	27370	\$ 931.00	☐ Indigency Discount
☐ Injection - Tigeminal Nerve Block	64400	\$ 1,633.00	☐ Injection - Shoulder Arthrogram	23350	\$ 736.00	☐ Other
☐ Injection - Occipital Nerve Block	64405	\$ 1,947.00	☐ Injection - Sacroiliac Joint	27096	\$ 1,627.00	Patient Initials: _____
☐ Injection - Sciatic Nerve Block	64445	\$ 918.00	☐ Fluoroscopic Guidance	77003	\$ 1,287.00	Charges and Payments
☐ Injection - Other Peripheral Nerve Block	64450	\$ 1,760.00	Other: _____			☐ Cash Payment \$ _____
☐ Inj - Intercostal Nerve Block - single	64420	\$ 2,555.00	ICD / Diagnosis			☐ Credit Card Payment \$ _____
☐ Inj - Intercostal Nerve Block - multiple	64421	\$ 3,526.00	1 _____ 3 _____			Total Charges \$ _____
☐ RF of Cervical Facet Joints - single joint	64633	\$ 5,153.00	2 _____ 4 _____			Balance \$ _____

I understand, agree and hereby certify that I am obligated to pay, and have been charged and billed TODAY for the above captioned itemized, and total or estimated global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & Patient Protection & Affordable Care Act (ACA), as: "The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay", and that I have no knowledge of any plan exclusion or limitation for the above charges in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise proactively arranged with applicable PPO or ACA discount. I am fully protected against any unexpected medical bills or charges by my provider's ACA Indigency Discount under provider's Corp. Indigency Policy, PPO Discount or Non-PPO Re-Pricing Discount from my health insurance or plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or good faith determination for my ACA Discount qualifications solely based on my unique ability to pay and individual healthcare need. I hereby assign the above billed charges as my legal claims to this provider as a full payment, as my authorized representative and a PPACA or ERISA Claimant, to claim or legally pursue for the proper reimbursement from my health.

Patient Signature: _____

Date: _____