Our Multispecialty Team Welcomes You!

arizonapaintreatmentcenters

MODERN AMBULATORY SURGERY CENTER

McDowell
ambulatory surgery center

Minimally Invasive
SPINE
Arizona's Minimally Invasive & Endoscopic Spine Surgery Specialists

OCA
On Call Anesthesia

You may see these names listed on your Explanation of Benefits from your health insurance carrier.
Questions? Contact your assigned account representative.

Who may we thank for referring you to our office? ◯ Medical physician_____

◯ Chiropractor_____ ◯ Family or friend _____ ◯ Internet ◯ Insurance company

PATIENT INFORMATION (Please complete all fields. If it does not apply or you do not want to provide, please write NA)

Last name_____ First name_____ Middle initial____ Birthdate _____Age_____

Street address_____Apt #_____

City_____State_____ Zip code_____

Home (_____)_____Cell (_____)_____Alt/work (____)_____Email_____

Driver's license_____ SS #_____ Male/Female_____

Marital status: ◯ Single ◯ Divorced ◯ Widowed ◯ Partner ◯ Married. Name of spouse _____

Race_____ Ethnicity_____ Primary Language_____

Employer_____ Occupation_____

Emergency contact _____Relationship_____ Phone (_____)_____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

Address_____ City / State / Zip _____Phone (_____)_____

ARE YOUR SYMPTOMS RELATED TO AN ACCIDENT? ◯ Yes ◯ No ◯ Don't know. Date of accident _____

If yes, what type? ◯ Auto ◯ On the job ◯ Other _____ Date reported_____

Is there an open claim related to this injury? ◯ No ◯ Yes State in which accident occurred_____

APPOINTMENTS
We ask that our patients come to their appointments 15 minutes before their scheduled time in order to fill out needed paperwork. If you are late, we will need to reschedule your appointment for a later time and date at our discretion.

PERMISSION FOR TREATMENT
I authorize the staff at "the Practice" to examine me and render treatment they deem necessary.

AUTHORIZATION TO RELEASE PATIENT INFORMATION
I authorize "the Practice" and its member physician to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate treatment and payment by third parties, collection of data for purpose of utilization review, quality assurance, or medical outcome evaluation purposes. Such information may be released to insurance companies, HMOs, PPOs, Managed Care organizations, IPAs or third party payers or any organizations contracting with any of the entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary or specialist physician that is directly or indirectly responsible for my medical care or the payment thereof.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received, reviewed and agree to the Notice of Privacy Practices of "the Practice," which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practices. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information.

_____

Print Name Signature Date

Date: _____ **DOB:** _____

Last name: _____ First name: _____

List other physicians you have seen regarding your condition *(specifically include any Rheumatologists, Neurologists, Orthopedic Surgeons, Spine Surgeons, or Chiropractic Physicians):* _____

_____

_____

Main pain complaint(s)	**Date started**	**Pain scale (0-10)**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Check whether you have had these treatments			**Approx last treatment**	**Approx relief %**
Chiropractic treatment	☐ Yes	☐ No	_____	_____
Physical therapy	☐ Yes	☐ No	_____	_____
Massage therapy	☐ Yes	☐ No	_____	_____
Psychology for pain	☐ Yes	☐ No	_____	_____

Check whether you have had these injections			**Approx Date**	**Relief**	
Epidural Steroid Injection	☐ Yes	☐ No	_____	☐ Yes	☐ No
Facet Joint Injection or facet block	☐ Yes	☐ No	_____	☐ Yes	☐ No
SI Joint Injection	☐ Yes	☐ No	_____	☐ Yes	☐ No
Radiofrequency Ablation	☐ Yes	☐ No	_____	☐ Yes	☐ No
Trigger Point Injection	☐ Yes	☐ No	_____	☐ Yes	☐ No

** List any other injections (joint, tendon, bursa, etc.)*: _____

PLEASE INDICATE IF YOU HAD, OR CURRENTLY HAVE, THE FOLLOWING MEDICAL PROBLEMS:

☐ Heart	☐ High Blood Pressure	☐ Pacemaker/defibrillator
☐ Bleeding or blood disorder	☐ Lungs/Shortness of Breath	☐ Sleep Apnea
☐ Kidney/Genitourinary	☐ Bladder/Bowel incontinence	☐ Stomach/Intestine/Acid reflux
☐ Nausea/Vomiting	☐ Diabetes	☐ Thyroid or another hormone
☐ Liver	☐ Hepatitis	☐ HIV
☐ Cancer	☐ Headache	☐ Stroke/TIA/paralysis
☐ Seizure	☐ Fracture	☐ Osteoporosis
☐ Joint/Muscle/Rheumatoid/Gout	☐ Skin Disorder	☐ Depression/Anxiety/other
☐ Suicidal ideation/attempt	☐ Fever recent/current	☐ Other

If yes to any of the above please explain and provide approximate date: _____

_____

_____

Family History

Mother: Alive or Deceased _____ Her medical conditions _____

Father: Alive or Deceased _____ His medical conditions _____

Do you smoke? **Do you drink alcohol?**

List any diagnostic tests you have had for this condition (MRIs, X-Rays, CT Scans, EMGs, etc.)

Date	Test	Body Part	Facility

_____

_____

_____

List all surgeries for brain, spine, joint, muscle and nerve (or any other major surgeries)

_____

_____

_____

Do you have **allergies** to latex, adhesive tape, contrast dye, iodine/shellfish or **medications**?
Please list the allergy and the reaction. _____

Have you had any problems with surgery or anesthesia?
Date/Reaction: _____

Is there anything else in your past medical history that you feel is important to your care here?

_____

Pharmacy Name: _____Phone #_____ Street: _____

Current medications

Name	Strength	Take	Route	Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Mark each box that applies

Male ◯ **Female** ◯

Are you under the age of 45? **Yes** ◯ **No** ◯

Is there any family history of substance abuse?

Alcohol	**Yes** ◯	**No** ◯
Illegal Drugs	**Yes** ◯	**No** ◯
Prescription Drugs	**Yes** ◯	**No** ◯

Do you have personal history of substance abuse?

Alcohol	**Yes** ◯	**No** ◯
Illegal Drugs	**Yes** ◯	**No** ◯
Prescription Drugs	**Yes** ◯	**No** ◯

Do you have a history of being sexually abused? **Yes** ◯ **No** ◯

Do you have any of the following psychological diagnoses?

ADD, OCD, bipolar, schizophrenia?	**Yes** ◯	**No** ◯
Depression?	**Yes** ◯	**No** ◯

Signature_____ Date_____

Auto Accident History to be Completed by the Patient

Patient name _____ Accident date _____

Make/Model/Year of **YOUR** vehicle _____

If other vehicle involved, name of **OTHER** driver _____

Make/Model/Year of **OTHER** vehicle _____

Accident type ○ Rear-end collision ○ Head-on collision ○ T-bone collision ○ Broadside ○ Non-collision ○ Other

You were the ○ Driver ○ Passenger / ○ Front seat ○ Back seat

Was **YOUR** vehicle moving at the time of the accident? ○ Yes ○ No

How fast would you estimate the **OTHER** vehicle was traveling? _____

Did you brace for impact? ○ Yes ○ No Did your airbag deploy? ○ Yes ○ No

Were you wearing your seatbelt? ○ Yes ○ No

Did your vehicle have headrests? ○ Yes ○ No If yes, what was the position of your headrest?

Top of the headrest was ○ even with bottom of head ○ even with top of head ○ even with middle of head

Was **YOUR** vehicle braking? ○ Yes ○ No Was the **OTHER** vehicle braking? ○ Yes ○ No

Was any body part struck by the car? ○ Yes ○ No Explain_____

Do you recall striking your head at impact? ○ Yes ○ No Explain _____

What position was your body in during impact? Looking straight ahead or turned? _____

Which hands were on the steering wheel? _____

What direction did your body move around the car at impact? ○ side-to-side ○ front-to-back ○ back-to-front

Were you evaluated at the scene of the accident? ○ Yes ○ No

Were you taken by ambulance to the hospital? ○ Yes ○ No If yes, which hospital?_____

Have you received any other medical attention since the date of the accident? ○ Yes ◉ No

If yes, the name of the clinic _____ Dates _____

Check all symptoms apparent SINCE the accident

☐ Headache	☐ Visual disturbance	☐ Forgetfulness	☐ Shoulder pain
☐ Neck pain	☐ Anxiety/Depression	☐ Lack of energy	☐ Elbow pain
☐ Mid back pain	☐ Lack of coordination	☐ Constipation	☐ Wrist pain
☐ Low back pain	☐ Difficulty walking	☐ Diarrhea	☐ Ankle pain
☐ Dizziness	☐ Difficulty concentrating	☐ Tingling	
☐ Sleep disturbance	☐ Ringing in ears	☐ Weakness	
☐ Bruising/cuts/scrapes	☐ Irritability	☐ Jaw pain	

Did you have any of your current physical symptoms BEFORE THE ACCIDENT? ○ Yes ○ No

If yes, please explain _____

Have you lost time from work as a result of this accident? ○ Yes ○ No

If yes, please complete Last day worked _____

If back to work, dates you missed work _____

Type of employment_____

Duties at work that you are unable to perform _____

List your % of work ability since the auto accident_____% *(0% = no capacity/unable to work...100% = full capacity/normal)*

Please list **THREE** activities of daily living that have been affected since the accident and your **% ability** for each

(for example: unable to play with kids 20%, unable to cook 80%, unable to drive 0%)

1)_____ ___% 2) _____ ____% 3)_____ ___%

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Notice of Doctor's Lien

Patient's Name: _____ Date of Accident: _____

I understand I may be a patient of Arizona Pain Treatment Centers, PC; McDowell Ambulatory Surgery Center, LLC; Modern Ambulatory Surgery Center, PC; On-Call Anesthesia Surgical, LLC; Minimally Invasive Spine, LLC. Hereafter referred to as **"The Practice".**

I do hereby authorize The Practice to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself regarding the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to The Practice such sums as may be outstanding for medical service rendered to me by The Practice and its staff and to withhold such sums from any settlement, judgment, verdict or recovery including but not limited to third party insurance, first party insurance, medical payments, personal injury protection or any funds recovered on my behalf related to the incident for which treatment was rendered, and as may be necessary to adequately protect and fully compensate the outstanding balances incurred by me with The Practice.

I hereby further assign to The Practice a lien against any settlement, judgment, verdict or recovery, including but not limited to third party insurance, first party insurance, medical payments, personal injury protection or any funds recovered on behalf of your client which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted by said provider for service rendered me and that this agreement is made solely for said provider's additional protection and in consideration of the provider awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said provider of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the provider's office. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment but may declare the entire balance due and payable.

_____	_____	_____
Dated	Patient's Signature	Patient Printed Name

_____	_____	_____
Dated	Attorney's Signature	Attorney's Printed Name

Please date, sign and ***return one copy to provider's office*** and keep one copy for your records.

I understand I may be a patient of:

Arizona Pain Treatment Centers, PC
McDowell Ambulatory Surgery Center, LLC
Modern Ambulatory Surgery Center, PC
On-Call Anesthesia Surgical, LLC
Minimally Invasive Spine, LLC

Hereafter referred to as “The Practice.”

I understand that Azmi Nasser, D.O. has a financial interest in McDowell Ambulatory Surgery Center, LLC.

_____
Patient printed name

_____ _____
Patient signature Date

Advance Directives

We are required to comply with federal and state law regarding advance directives for adults and include this information in your medical chart. ***If you have a Living Will or Medical Power of Attorney, please bring it to your next appointment so we may scan it into your chart.***

An “Advance Directive” is a general term that refers to your oral and/or written instructions about your future medical care, in the event that you become unable to speak for yourself. Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and a medical power of attorney. If you would like a copy of the Official AZ State advance directive forms, please visit http://www.azsos.gov/adv_dir/

◯ **I have a Medical Power of Attorney.**

◯ **I have a Living Will.** My Living Will
(Please select one) ◯ **Does** ◯ **Does Not** contain a DNR (Do Not Resuscitate) order. ***

◯ **I have neither of the above.**

****** “Do Not Resuscitate” directives are not accepted by “the Practice” and you will asked to sign an override if your Living Will contains one.***

Patient Billing Information

Date_____ **Patient's Name:** _____

Please complete each box. If it does not apply, please write NA.

HEALTH INSURANCE PRIMARY:

Insurance Co_____ Telephone # to verify benefits**:**_____

Name of Insured**:**_____

Insured's Soc. Sec. #_____DOB_____

Group #_____ Policy #_____

Mail claims to:_____

HEALTH INSURANCE SECONDARY:

Insurance Co_____ Telephone # to verify benefits**:**_____

Name of Insured**:**_____

Insured's Soc. Sec. #_____DOB_____

Group #_____ Policy #_____

Mail claims to:_____

Workers' Compensation Insurance Company:

Insurance Co_____ Address:_____

Phone:_____ Case Manager:_____ Date of Injury_____

Claim #:_____ Is Claim still Open?_____

PERSONAL INJURY **Date of Injury:** _____

Auto Insurance Coverage: (Your auto insurance)

Insurance Co:_____ Name of Insured:_____

Address:_____

Insurance Phone:_____ UM/UIM Coverage:_____

Auto Insurance Coverage: (Medpay Claim)

Insurance Co:_____ Name of Insured:_____

Address:_____

Insurance Phone:_____ Adjuster:_____

Medpay Limits: $_____ Is Claim Open? _____ Claim #:_____

Third Party/Liability Insurance Company: (Insurance info for at-fault vehicle)

Insurance Co _____ Name of Insured:_____

Address: _____Adjuster Phone:_____ Adjuster: _____

Is claim still open? _____ Policy/Claim #:_____

Attorney's name:

Attorney's Name:_____ Law Firm: _____

Phone:_____ Contact Person_____ E-Mail_____

Address:_____ Liens to file: County Attorney

Assignment of Benefits and Designation of "The Practice" as 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 of 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.

_____

Patient Signature

_____

Date

Financial Policy and Disclosure of Fees

Our office files insurance claims as a courtesy for all of our patients. **If your insurance changes, please notify us immediately so that we can be sure we have the appropriate referral and eligibility verification.** You are **responsible** for all bills regardless of the type of insurance coverage you may have. Please contact your insurance company for any questions you have regarding coverage of services as it is your responsibility to know your benefits. We allow 60 days for your insurance to pay. After that time, the unpaid balance may be due and payable by the patient.

Payment is expected at time of service. Patients are responsible for the appropriate co-payment, deductible and **co-**insurance. Payment may be made with cash, credit card or money order. **We do not accept personal checks at time of service**. If your credit/debit or mailed check is returned for insufficient funds, you will be charged a $35.00 service charge.

You are expected to pay all charges at the time of service if:

1. You have no insurance coverage
2. Proper authorization/referral has not been received.

Delinquent Accounts

Accounts past due are subject to collection. All fees including, but not limited to collection fees, attorney fees and court fees incurred shall become your responsibility in addition to the balance due this office.

Personal Injury

Our office will accept personal injury cases. If we accept your case on a lien basis, there will be a lien filing fee of $20 applied to your account at the beginning of treatment for "the Practice." If you have a procedure done at either ambulatory surgery center, an additional $20 fee will be added to your account to cover the ASC's costs for lien filing. Payment for treatment is not contingent on any settlement, judgment or verdict which you may eventually recover. Lien cases will be reviewed periodically and you may be required to make payments for continued care as determined by our office. You will be notified in advance.

Verification of Benefits

Our office will verify your insurance benefits as a courtesy and it is not a guarantee of payment. Your insurance is a contract between you and your insurance company. You are liable for all expenses incurred and should any expenses remain unpaid for any reason, including but not limited to insurance deductible, policy limits or exclusions, you agree to pay any amounts remaining and owed to our office.

Disclosure of Fees

99204	Intermediate Initial History and Exam	$469.50
99213	Limited office visit (7-10 minutes)	$204.50
99214	Intermediate office visit (10-15 minutes)	$303.50
97110	Therapeutic exercises 15 minutes or less	$69.50
98940	Manipulation	$64.50
97140	Manual therapy each 15 minutes	$59.50
20553	Trigger Point Injection	$135.50
20610	Bursa/major joint Injection	$172.50
64483	Epidural Steroid Injection Professional Fee	$1212.50
64483	Epidural Steroid Injection Facility Fee ea. level	$2399.00
64635	Radiofrequency Neurotomy Injection Professional Fee	$1485.50
64635	Radiofrequency Neurotomy Facility Fee ea. level	$2399.00
63030	Surgical Decompression Professional Fee	$30,808.00
99144	Conscious/Moderate Sedation	$250.50

The Disclosure of Fees is not a complete list but only a sample of services we provide.
We utilize both in- and out-of-network patient benefits.

I have read and understand the financial policy and prices. I acknowledge liability for all medical expenses incurred and agree to abide by the terms of this policy. Furthermore, with my signature, I authorize my physicians and their representatives to pursue collection via small claims court or higher court of law to assist me in collection of any outstanding bill.

Patient Signature _____ Date _____

Patient Name (print)_____

Member Authorization Form for a Designated Representative to Appeal a Determination

TO: Appeals Department

DATE: _____

Member Name: _____

Member ID #: _____

I hereby authorize _____ to appeal _____ determination
(*Print name*)
concerning _____on my behalf, as my
(*Description of service and date of determination or reference number*)
Designated Representative, and, as part of the appeal, I hereby authorize _____ in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative concerning the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/Representative

_____
☐ Signature of Witness ☐ Designated Representative (Check One)

_____
Name of Witness/Designated Representative (Please Print)

_____
Title (if on provider's staff) or Relationship to Member

Patient Bill of Rights

- ✓ To be treated with respect, consideration and dignity
- ✓ To expect quality care and service from this facility
- ✓ To know, in advance, the estimated amount for services
- ✓ To full consideration of privacy concerning your medical care
- ✓ To information concerning your diagnosis, treatment and prognosis, to the degree known, in terms you can understand. If concern for your health makes it inadvisable to give such information to you, such information will be made available to an individual designated by you or to a legally authorized individual
- ✓ To receive from your physician sufficient information to be able to understand the procedure or treatment being received in order to sign the operative consent
- ✓ To confidential treatment of your medical records and to know that you are given the opportunity to approve or refuse their release to outside parties except when otherwise required by law
- ✓ To refuse treatment and to be informed of the consequences of this action
- ✓ To be given the opportunity to participate in decisions involving your healthcare, except when such participation is contraindicated
- ✓ To be informed of any persons other than routine personnel that would be observing or participating in the treatment
- ✓ To be informed of continuing healthcare you will receive following discharge
- ✓ To receive prompt pain assessment, treatment and information concerning pain prevention and relief measures
- ✓ To be free from all forms of abuse or harassment or from any act of discrimination or reprisal.
- ✓ If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
- ✓ The patient's representative has the right to make informed decisions regarding the patient's care.
- ✓ If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

PATIENT CONCERNS AND/OR GRIEVANCES:

Persons who have a concern or grievance regarding "the Practice," including, but not limited to decisions regarding admission, treatment, discharge, denial of service, quality of services, courtesy of personnel or any other issue are encouraged to contact the Director of Operations or write a statement to:

Director of Operations: "The Practice" 1301 E. McDowell Road, Suite 100 Phoenix, AZ 85006

To file a complaint against an M.D., visit the Arizona Medical Board website to review options:
https://www.azmd.gov/Complaint/ComplaintOL.aspx

Medicare patients should visit the website to understand your rights and protections:
http://www/cms.hhs.gov/center/ombudsman.aspx

I have read and acknowledge my rights as a patient.

Signature _____ Date _____

The Practice
Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

The ASC may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulation or state law. Disclosures of your protected health information for the purposes described in the Privacy Notice may be made in writing, orally or by facsimile.

Treatment: We will use and disclose your medical information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order blood work. We may also disclose protected information to physicians who may be treating you or consult with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

Payment: Your medical information will be used, as necessary, to obtain payment for services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your insurance company for utilization review. We may also disclose patient information to another provider in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia providers for payment of their services.

Operations: We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the ASC and to provide quality care to all patients. Health care operations activities include, but are not limited to, training programs including those in which student, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing, or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, business management and general administrative activities.
In certain situation, we may also disclose patient information to another provider or health plan for their health care operations.

Other uses of Disclosures: As part of treatment, payment and health care operations, we also use or disclose your protected health information for the following purposes:

- To remind you of your surgery date
- To inform you of potential treatment alternatives or options
- To inform you of health-related benefits or services that may be of interest to you.

We may release medical information about you to a friend, family member, or personal representative who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the surgery center. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through the research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility. We will always ask for your specific permission (authorization) if the researcher will have access to your name, address or other information that reveals who you are, or what will be involved in your care at the surgery center.

We will disclose medical information about you when required to do so by federal, state or local law.

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be limited to someone able to help prevent the threat.

Uses and disclosures beyond treatment, payment and health care operations permitted without authorization of opportunity to object. Federal Privacy rules allow us to use or disclose your

protected health information without your permission for a number of reasons including the following:

- When legally required.
- When there are risks to public health.
- To report suspended abuse, neglect or domestic violence.
- To conduct health oversight activities.
- In connection with judicial and administrative proceedings.
- For law enforcement purposes.
- To Coroner, Medical Examiners, Funeral Directors and for organ donations.
- For research purposes.
- In the event of a serious threat to health or safety.
- For specified Government functions. .
- For Worker's Compensation.

Uses and disclosures permitted without authorization but with opportunity to object. We may disclose your protected health information to your family member or a close personnel friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connecting with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described:

- Uses and disclosures with you authorize. Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.
- Your rights. You have the following rights regarding your health information:
  - The right to inspect and copy your protected health information. To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record.
  - The right to request a restriction on uses and disclosures of your protected health information. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.
  - The right to request to receive confidential communications from us by alternative means or at an alterative location. Requests must be made in writing to our Privacy Officer.
  - The right to request amendments to your protected health information. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.
  - The right to receive an accounting. You have the right to request an accounting of certain disclosures of you protected health information made by the facility. The request should specify he time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during a 12-moth period without charge. Subsequent accounting request may be subject to a reasonable cost-based fee.
  - The right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice, even if you have already received a copy of the notice or have agreed to accept this notice electronically.

Our Duties The facility is required by law to maintain the privacy of your health information and provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by the terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

Complaints You have the right to express complaints to the facility and to the Security of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility, you may submit a complaint to our Privacy Officer by sending it to:

The Practice
Attn: Director of Operations / Privacy Officer
Address: 1301 E. McDowell Rd., Suite 100
Phoenix, AZ 85006
Phone: 602-265-8800